1-1-1991

Therapists' characteristics and gender stereotypes by age, race, and sex of target.

Judith Ann Burnett
University of Massachusetts Amherst

THERAPISTS' CHARACTERISTICS AND GENDER STEREOTYPES BY AGE, RACE, AND SEX OF TARGET

A Dissertation Presented

by

JUDITH ANN BURNETT

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

September 1991

Department of Psychology

THERAPISTS' CHARACTERISTICS AND GENDER STEREOTYPES BY AGE, RACE, AND SEX OF TARGET

A Dissertation Presented

by

JUDITH ANN BURNETT

Approved as to style and content by:

Castellano Turner
Castellano Turner, Chairperson

Barbara F. Turner
Barbara Turner, Member

Howard Gadlin
Howard Gadlin, Member

David Todd
David Todd, Member

Arnold Well
Arnold Well, Member

Melinda Novak
Melinda Novak, Acting
Department Head
Department of Psychology

DEDICATION

In honor of my parents,

Frank and Gwendolyn Burnett,

my grandmother,

Evelyn J. Wagner,

and

in memory of my grandmother,

Margaret R. Burnett,

for their love, support, guidance, and confidence in me.

ACKNOWLEDGMENTS

This research project was realized through the assistance of many individuals at every stage of development. I would like to express my gratitude to those persons who have contributed:

My dissertation advisor, Dr. Castellano Turner, graciously gave his time, support, and insightful direction. With his guidance, I have continued to grow and build my confidence as a psychologist, researcher, and individual.

Dr. Barbara Turner served on my committee and provided encouragement, guidance, and support throughout this project.

The other members of my dissertation committee, Dr. Howard Gadlin, Dr. David Todd, Dr. Arnold Well, provided helpful suggestions and enriched my experience with their counsel.

I am grateful to the staff of the Georgetown University Counseling and Psychiatric Service for their encouragement and help in preparation of the manuscript.

I thank my friends for their encouragement, support, patience, and love - Michael Evans, Dr. Gwendolyn Ford, and Beth Warner.

Finally, I owe the deepest gratitude to my family: Frank and Gwendolyn Burnett, John Burnett, Evelyn, Gloria, and Joelle Wagner, William, Gail, Terri, and Joshua Seeney, and Margaret Burnett. Words cannot begin to express the important role that they have played in this project and my

development. Their love, patience, faith, and support have made all of my work and success possible.

I thank God for everything and everyone.

ABSTRACT

THERAPISTS' CHARACTERISTICS AND

GENDER STEREOTYPES BY

AGE, RACE, AND SEX OF TARGET

SEPTEMBER 1991

JUDITH ANN BURNETT, A.B., BROWN UNIVERSITY

M.S., UNIVERSITY OF MASSACHUSETTS

Ph.D., UNIVERSITY OF MASSACHUSETTS

Directed by: Professor Castellano B. Turner

The investigation examined the relationship between various clinician variables and clinicians' gender stereotypes for men and women varying in age and race. Randomly selected white psychotherapists listed in the National Register of Health Care Providers in Psychology used the Bem Sex-Role Inventory (BSRI) to rate a "mature, healthy, socially competent individual" in one of 12 target groups (a black or race unspecified man or woman in their late 20s, late 40s, or late 60s). Three scale scores (Nurturant, Agentic, and Self-Governing) were utilized that were based on a factor analysis of the 40 feminine and masculine BSRI subscale items.

A Personal Data Survey attached to the BSRI provided information on therapist characteristics. The information utilized included theoretical orientation, amount of contact with various categories of clients, and the year of the highest degree received.

It was found that on the masculine-associated scale, Agentic, there was a significant association between theoretical orientation and gender stereotypes. Clinicians identified as dynamic and eclectic viewed targets as most agentic while clinicians identified as behavioral-rational rated targets as least agentic. There were no significant interaction effects nor were there significant main effects or interactions on the Nurturant or Self-Governing scales.

It was also found that on the scale Agentic, there was a significant interaction between respondents' percentage of black clients and the sex of target rated. The greater the percentage of black clients, the more likely was the therapist to rate black male targets as more agentic. For black female targets, the greater the percentage of black clients, the more likely was the therapist to rate these targets as less agentic.

Finally, it was found that on the scale Agentic, the degree of similarity between respondents and target (on sex, age, and race) was significantly related to gender stereotypes. The greater the similarity between respondent and target, the more likely were respondents to view targets as more agentic.

The findings suggest that masculine-associated characteristics pull for more stereotyped responses over feminine-associated characteristics and this varies by the clinician variables studied.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

The purpose of this study was to examine the relationship between therapists' characteristics (e.g., therapist age, theoretical orientation) and their gender stereotypes for targets varying in age, sex, and race. The area of gender stereotypes is one that has received considerable attention from researchers for some time. This research has tackled topics ranging from gender stereotypes around social behavior and occupations to the impact of gender stereotypes on psychotherapy. There has been considerable research on psychotherapists' gender stereotypes, particularly following the classic Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) study, which indicated that there indeed was a different standard of mental health for men and women. However, little work has been done which addresses gender stereotypes for targets of different ages and races. The social cognition literature proposes that the concepts of sex, age, and race may create reciprocal effects (Futoran & Wyer, 1986) on one's social perceptions of others due to their equal level of abstraction (cf. Messick & Mackie, 1989). However, there is limited knowledge about the interaction of social category concepts at the same level of generality (Messick & Mackie, 1989). To shed some light on this matter, Turner and Turner (1987) performed a study which examined gender

stereotypes for men and women varying in age and race. Their study found that age and race play a role in clinicians' assessments of mental health. Given these findings, it seems important to also examine the characteristics of the clinician that may be informing and influencing his or her perceptions of psychological health for adults. For the purpose of this study, gender stereotypes are defined as structured sets of beliefs or generalizations about the characteristics of men and women (cf. Ashmore & Del Boca, 1986). Also, in the following discussion, the terms gender and sex will be utilized. The term "sex" will be used when addressing anatomical or biological identification while the term "gender" will be used when describing more psychological phenomena including more subjective attributes such as adopted sex roles.

Stereotypes: Definitions and conceptual clarification

As aforementioned, there has been a large volume of research performed in the area of stereotypes. A stereotype has been defined as an oversimplified generalization by which we attribute certain traits or characteristics to any person in a group without regard to individual differences (cf. Worchel & Austin, 1986). These beliefs are roughly analogous to perceptual illusions. It is important to have some understanding of stereotypes and their formation and preservation in that they may support prejudice (unjustified negative attitudes toward a group and its members) which in turn can lead to discrimination (unjustified negative

behavior toward a group and its members)(cf. Myers, 1983). The social cognition literature indicates that when presented with little information about an individual or when just commencing interaction with an individual, there is a tendency to make judgments based on stereotypes (cf. Myers, 1983). This would be of particular importance in the psychotherapeutic arena in that at the outset of treatment, it can be assumed that there is limited information about a particular person. Stereotypes and their subsequent consequences may influence one's ability to effectively establish a working alliance, particularly when treating an individual significantly different from oneself.

Stereotyped beliefs and prejudiced attitudes exist not only because of social conditions (e.g., unequal status breeds prejudice) and because they serve an emotional function (e.g., enabling people to displace and project their hostilities) but also as by-products of normal thinking processes. A stereotype does not have to have malicious origins. As cited previously, stereotypes are overgeneralizations -- ways of simplifying a complex world. One manner in which individuals simplify is to categorize into groups. One social cost of this manner of categorization is ingroup bias or the tendency to favor one's own group (Myers, 1983). Ethnicity, sex, and age are powerful ways of categorizing people (Taylor, Fiske, Etcoff, & Ruderman, 1978). Once people are categorized, there is a tendency to exaggerate the similarities within groups and

the differences between them (Taylor, 1981; Wilder, 1978). Consequently, mere division into groups can create a sense that members of a particular group not one's own group, are "all alike" but different from oneself and one's own group (Allen & Wilder, 1979). It has been well established that we tend to like or favor people we perceive as similar to ourselves and tend to dislike those perceived as different. This alone could provide a basis for ingroup bias (Rokeach & Mezei, 1966).

This tendency to see people in another group as more similar to one another than they really are is less true of perceptions of one's own group. Watson (1981) reports that white Americans readily identify "black leaders" who supposedly speak for all black Americans. Whites apparently presume that whites are considerably more diverse, for they do not assume that there are white leaders who can speak for white America.

This perception that "they are alike, we are diverse" extends even to perceptions of physical characteristics. Experiments such as those done by Chance and Goldstein (1981) and Brigham and Williamson (1979) reveal that people of other races do in fact appear to look more alike than do people of one's own race.

Other ways in which we perceive the world can also breed stereotypes. For example, vivid distinctive cases get remembered and can fuel stereotypes. There is a tendency to overgeneralize from distinctive or vivid cases. Quattrone

and Jones (1980) report that the tendency to form stereotypes (from the behavior of a single person) is especially strong when that person is a member of an unfamiliar group and one's prior expectations are weak. The less knowledge we have about a group and its behavior, the more likely we are to be influenced by a vivid case and generalize.

Distinctive cases can produce illusory correlations or false impressions that two variables are associated (e.g., gender and intelligence or race and mental health). Due to the tendency toward sensitivity to distinctive events, the co-occurrence of two such events is especially noticeable. Hamilton and Rose's (1980) research revealed that preexisting stereotypes can lead individuals to "see" correlations that are not there. They had students read sentences in which the members of different occupational groups were described by various adjectives (e.g., "Doug, an accountant, is timid and thoughtful"). In actuality, each occupation was described equally often by each adjective; accountants, doctors, and salespeople were equally often reported to be timid, wealthy, and talkative. However, the students thought they had more often read descriptions of timid accountants, wealthy doctors, and talkative salespeople. Their stereotyping lead them to perceive correlations that were not there, thus helping to perpetuate the stereotypes (McArthur & Friedman, 1980).

Another basis for stereotypes is the fundamental attribution error, i.e., attributing behavior so much to inner dispositions that situational factors become discounted. This error can occur because the focus tends to be on the person him or herself, not on the constraints of the situation. For example, the race or sex of a person is vivid and attention-getting where role requirements or situational forces working on a person are more invisible. For instance, the behavior of slaves tended to be attributed to their own nature; the conditions of slavery were overlooked as a possible explanation for certain behaviors of slaves. Pettigrew (1980) argues that the fundamental attribution error becomes the "ultimate attribution error" when people explain the action of people in groups. Positive behavior by outgroup members is more likely to be dismissed in one of several ways: as a "special case" (e.g., he's bright and hardworking not like other blacks) or as due to luck or special advantage (e.g., she got in due to quotas) or finally by attributing it to extra effort (e.g., Jews get better grades because they are so compulsive).

It can be postulated that stereotypes direct interpretations. When a member of a group behaves as expected, the fact is duly noted and the prior belief is confirmed. When a member of a group behaves inconsistently with the expectation, the behavior is explained away as due to special circumstances (Crocker, Hannah, & Weber, 1983) or it may be misinterpreted, leaving the prior belief intact.

Ickes and his colleagues (1982) in their investigation using pairs of college-age men demonstrated one reason why misinterpretation occurs. Upon arrival, one member of each pair was falsely forewarned by the experimenters that the other member of the pair was "one of the unfriendliest people I've talked to lately." The two were then introduced and left alone together for five minutes. As did students in another condition, who were led to think the other subject was exceptionally friendly, those who expected him to be unfriendly went out of their way to be friendly to him, and their smiles and other friendly behaviors elicited a warm response from him. But unlike the positively biased students, those expecting an unfriendly person apparently attributed this reciprocal friendliness to their "kid-gloves" treatment of him. Hence, they afterward expressed more distrust and dislike for the person and rated his behavior as less friendly. It seemed that, despite their partner's actual friendliness, the negative bias had induced these students to "see" hostilities lurking beneath his "forced smiles."

The above is not to say that stereotypes are impenetrable. Locksley and her colleagues (1982) found that once one knows a person, "stereotypes may have minimal, if any impact on judgments about that person." Their study looked at gender stereotypes and perceptions of assertiveness. They found that their subjects' expectations of how assertive a person would be were affected solely by

what they had learned about the individual the day before. They gave students anecdotal information about recent incidents in the life of "Nancy." In a fictional transcript of a telephone conversation, Nancy told a friend how she responded to three different situations. Some students read transcripts where Nancy behaved assertively; others portrayed passive responses. Other students had identical information except the person was "Paul" instead of "Nancy." A day later students were asked to predict how Paul or Nancy would respond to other situations. Even judgments of the person's masculinity or femininity were unaffected by knowing the person's sex. Nancy and Paul were evaluated as individuals. Gender stereotypes were not utilized. Vivid information (even when anecdotal or trivial) usually overwhelms more general or categorical information. This could lead one to conclude that when stereotypes are strong and information about someone is general or categorical (e.g., sex, age, ethnicity) that stereotypes can subtly bias judgments of an individual. As indicated in the Turner and Turner (1987) study, when presented with general information, there indeed was evidence that strong gender stereotypes exist and that they do vary by age and race.

In summary, it appears that stereotypes have the potential to be quite influential in person perception judgments. Stereotypical thinking has a number of causes (e.g., emotional, social, cognitive) and may produce subsequent effects (e.g, prejudice, discrimination). The

biases produced by this thinking can be positive or negative in nature. It is also important to note finally that stereotypes are not impenetrable and that the more information an individual possesses about another, the less likely stereotypical thinking is to affect person perception judgments.

Gender stereotypes and their measurement: Bem Sex-Role Inventory

Given the important role that stereotypes can play in our judgments of others, it is important to be able to measure these biases. This measurement would allow one to determine what specific stereotypes may be in effect. This information is important so that possible misperceptions could be addressed and corrected. For the purpose of this study, gender stereotypes will be addressed.

The personality traits associated with women and men have been well documented and are typically characterized in terms of two orthogonal dimensions (Deaux & Lewis, 1983; Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968). Men's personality characteristics are represented by a cluster of traits such as independent, self-confident and dominant, labeled "agentic" in Bakan's (1966) terms. Women's characteristics are represented by a cluster of traits such as affectionate, aware of others' feelings, and able to devote self to others, which Bakan terms "communal". Deaux and Lewis (1983) have extended this work by delineating two other important aspects of the gender

stereotype: role behaviors and physical characteristics. These authors found that men are seen as more likely to engage in certain role behaviors, such as being head of the household and taking initiative with the opposite sex, whereas women are seen as more likely to engage in such role behaviors as taking care of children and cooking the meals. Similarly, women and men are thought, on a probabilistic basis, to possess different physical characteristics; men are believed to be tall and strong, and women are believed to be soft and graceful.

Information about one component of the gender stereotype heavily influences inferences about other gender-related attributes (Deaux & Lewis, 1984). Thus, if a woman is described as possessing masculine traits, such as independence and self-confidence, she is believed more likely to have masculine physical characteristics and engage in masculine role behaviors. These results suggest that although knowledge of biological sex informs the perceiver about the characteristics a man or woman is likely to exhibit, additional detail about his or her characteristics can outweigh this basic category information. At the same time, there is coherence to the gender belief system (Deaux & Kite, 1987) that channels information processing in stereotypic ways.

The Bem Sex Role Inventory is one measure that has been widely used in gender stereotyping literature (BSRI; Bem, 1974). The Bem scale is now viewed as a set of traits,

especially personality traits. Recent literature (Deaux & Lewis, 1983; Spence & Sawin, 1985; Ashmore, Del Boca, & Wohlers, 1986) suggests that gender stereotypes are multidimensional, including traits, role behaviors, interests and physical-sexual attributes which tend to be highly salient in face-to-face interactions. The BSRI includes only traits and it has been found that respondents make fewer gender distinctions on personality traits than on other gender-stereotypical dimensions (Kite, Deaux, & Miele, 1991).

Self-descriptions on the BSRI, which contains 20 masculine-associated, 20 feminine-associated, and 20 supposedly gender neutral traits, have been factor-analyzed in several studies of student samples (Gaudreau, 1977; Pedhazur & Tetenbaum, 1979; Ruch, 1984). Factor analyses with orthogonal varimax rotations produced four rather than two (masculine and feminine) factors in all of these studies. One factor has usually contained almost all the masculine-associated traits except for the item "masculine"; one has contained many of the feminine-associated traits, but not the item "feminine"; a third has primarily contained the remaining feminine-associated traits--less socially desirable traits such as gullible, childlike and shy; and the fourth has been a bipolar factor comprised of the two items masculine and feminine. The classification of the other factors as masculine or feminine has been questioned due to the appearance of this bipolar factor (Pedhazur &

Tetenbaum, 1979). The dimensions underlying the bipolar gender factor have not been explored by the aforementioned researchers.

For the Turner and Turner (1987) study, it was predicted that the factor structure for gender stereotypes attributed to others would approximate the factor structures found in studies of self-attributions. The specific purpose of their study was to use scales derived from a factor analysis of the BSRI to describe differences in gender stereotypes for targets varying in age, sex and race. For the present study, the same model was followed with the added dimension of investigating respondents' characteristics.

Determinants of variation in stereotyping

Target variables

Target sex. Stereotypes held by psychotherapists may greatly hinder effective psychotherapy (Acosta, Yamamoto, & Evans, 1982). It has been found that gender and other stereotypes do play a role in social interactions (Ashmore, et al., 1986). This is important because it has been found that one's expectations can influence one's behavior in a way that confirms the initial expectation (Jones, 1978). This indicates that there is a relationship between stereotypes and behavior. In short, this could be the very thing that can have a negative effect on the cross-sex therapeutic alliance.

In their study examining age, sex, race, and clinical judgments of mental health, Turner and Turner (1987) found that white psychotherapists' beliefs about sex differences on certain masculine traits are strongly influenced by the target's age and race. Middle-aged black women and "adults" are viewed less positively than their white counterparts. This is important because there has been considerable research on therapists' gender stereotypes and how this impacts on the conduct of psychotherapy. The classic Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) study indicated that there was a "double standard of mental health for men and women." In short, they found that their respondents were more likely to attribute trait characteristics of healthy adult to a healthy man than to a healthy woman.

In other studies on gender stereotyping and mental health, there have been a myriad of findings. Although opinions vary, many believe that women have suffered from the bias and stereotyping of counselors and therapists. There are indications that support this hypothesis. For example, testimony and evidence regarding the proposed Mental Health Systems Act presented to a congressional subcommittee (Felipe-Russo, 1979) cited sex bias against women in the mental health delivery system. Therapist bias can also be quite varied. For instance, Tanney and Birk (1976) concluded that both male and female counselors have biases toward women, sometimes viewing them excessively

favorably and sometimes excessively unfavorably. In her review of women and gender stereotyping, Sherman (1980) judged the data as providing evidence that gender values of therapists are operative during counseling; that there is gender stereotyping in mental health standards and that behavior that crosses sex-role norms is judged more negatively.

Smith (1980) reviewed research on counseling attitudes, stereotypes and behavior and did a "meta-analysis" of sex bias studies. Her analysis revealed that "there is no evidence for the existence of counselor sex bias when the research results are taken as a whole." (p. 404). She concluded that empirical support for sexism in psychotherapy is weak and that the evidence leaning toward bias is balanced by the evidence against it. In his review of the status of research on the effects of gender stereotypes on mental health judgments, Whitley (1979) concluded that gender stereotypes are strong mental health cues for nonprofessionals, with violations of gender norms leading to adverse mental health judgments, but that while professionals share the gender stereotypes of their lay contemporaries, the professionals are unaffected by them in making mental health judgments and in setting therapeutic goals. In their study which examined sex stereotypes and clinical judgments of mental health among marital and family therapists, Ciano-Boyce, Turner, and Turner (1988) found that clinical judgments about the traits characterizing

healthy, mature men did differ from judgments about the traits characterizing healthy mature women. They also found that judgments of the healthy "adult" were more like those for a male than for a female. Finally, a study by Rogers (1985), which investigated gender stereotyping in clinicians' judgments of mental health, found that there are differences in the perceptions held by professional therapists regarding men and women. However, analyses revealed that traditional feminine traits were regarded more favorably than in the research by Broverman and colleagues (1970) and were viewed as characteristics appropriate for adults in general. Overall, these studies provide a confusing range of findings and no definitive conclusions.

Target age. Research focusing on age has gained increasing popularity over the years. Characteristics associated with older individuals are not well defined, but there is general agreement that the stereotype is multidimensional and includes characteristics such as ill, tired, grouchy, unlikely to participate in activities, unhappy, undesirable for company and physically unattractive (Crockett & Hummert, 1987; Lutsky, 1980; Miele & Deaux, 1989). Less certain is whether older individuals are consistently evaluated more negatively on these characteristics than are younger individuals. In their meta-analysis of this research, Kite and Johnson (1988) concluded that although there was an overall bias against the elderly, the effect could be diminished by several

factors, such as providing specific information about the stimulus persons, using a between-subjects rather than a within-subject design, and assessing traits rather than physical appearance or competence.

There has been limited work done on attitudes regarding mental health for the aged. In the studies that are available, there are generally few psychologists in the samples. In a review of the early literature, Bennett and Eckman (1973) found that societal attitudes toward older people were largely negative. In a similar review, Lutsky (1980) concluded that rather than pervasive negative attitudes toward the elderly, the studies indicated a less favorable position when compared to other age groups. In somewhat more recent work, Knight (1985-86) found that therapists were more positive than college students toward the elderly, and Garfinkel (1975) found positive attitudes toward the elderly. In studies focusing on diagnosis, age has been shown to be a more potent main effect than it has in attitude studies. Ford and Sbordonne (1980) found that mental health professionals more frequently recommended drugs rather than psychotherapy to treat depression in older patients as opposed to younger ones. Poorer prognoses for older hypothetical patients have been found as well (Ray, McKinney, & Ford, 1987). The age literature presents a somewhat confused picture and seems to indicate that there may be multiple stereotypes in operation. In their review of research on attitudes toward the aged, Gatz and Pearson

(1988) suggest that there does not seem to be a global negativity toward the aged but instead there may be specific treatment biases and that others are based on positive misconceptions. They point to the significance of the overestimation of Alzheimer's disease and how this threatens to overwhelm other stereotypes.

Although only a few studies have considered sex-of-target differences in perceptions of the elderly, beliefs about older women and men appear to differ. Women are thought to reach middle and old age (Drevenstedt, 1976) and the prime of life (Zepplin, Sills & Heath, 1987) earlier than men. Furthermore, the "best age" to marry, be a parent, have the most responsibilities, and have accomplished the most is judged to be later for men than for women (Zepplin et al., 1987). Finally, Deutsch, Zalenski, and Clark (1986) found that elderly men were seen as more attractive than elderly women, but there were no differences in ratings of middle-aged or young women and men. Moreover, these findings also indicate that the double standard for aging is more likely to be endorsed by men than by women (Zepplin et al., 1987).

The multidimensionality of the stereotype of old people has often been noted (Lutsky, 1980), but few studies have examined more than one of these dimensions. The limited research on sex and aging suggests that older women are evaluated more harshly than men, but this may be especially true when physical appearance is examined, as suggested by

the research on the double standard of aging. In other areas, such as traits, younger and older persons may be rated similarly (Kite & Johnson, 1988).

The above presents a mixed interpretation of attitudes toward older adults. However, it does seem clear that although there may not be global negative attitudes toward the elderly, specific biases may exist. These biases may affect the provision of mental health services to this age group.

Target race. Important sociocultural factors in the psychological assessment and treatment of minority group patients may often be overlooked or misinterpreted by psychotherapists. It seems necessary for therapists to be open to sociocultural factors as they influence the assessment of psychopathology and the therapeutic alliance. For the work of psychotherapy to be most effective, it is important to be able to develop an environment that enables the black client to explore and understand his or her own motives and actions through self-disclosure. The trust necessary for self-expression evolves out a client's belief in the therapist's ability to understand who they are and the problems they bring into therapy. The psychotherapist should be aware of a variety of issues in order to adequately develop a trusting and supportive therapeutic environment.

There are unique barriers that can hinder therapeutic work with a person from a minority culture. The United

States has a lengthy history of discrimination and oppression toward minority cultures by the majority culture. The field of psychology has not been immune from discrimination and oppression toward minority cultures. There are a number of tenets that have informed ethnic minority research and practice. The first, referred to as the inferiority model, assumes that certain ethnic groups are considered inferior to whites. The second, or the deficit model attributes the plight of ethnic minority groups to their disadvantaged social condition. Prejudice and discrimination create stress for minorities. This stance neglects strengths and competencies. It is assumed that assimilation is the key to mental health and deviance is considered pathological. Instead of viewing behaviors which differ from white middle-class norms as adaptive responses to inequities in the social structure, or simply stemming from cultural diversity, social scientists have often enlisted this deficit model instead of a difference model to explain these variations. The third, which is now a more popular trend, is a bicultural or multicultural model where the minority group is viewed as a function of a) ethnic values, b) U.S. or Western values, and c) an interaction of the two sets of values (Sue, Ito, & Bradshaw, 1982). Jones and Korchin (1982) outline several problem areas in race/ethnic minority research that could also be applied to practice. They posit that 1) there is an assumption that a given culture is homogeneous, 2) most

things are standardized based on white groups, 3) findings are frequently interpreted utilizing a deficit model, 4) ideological and political resistance has stymied minority researchers from assuming leadership roles, 5) controlling for socioeconomic status and acculturation levels is difficult, and 6) that even if separate norms are used, can one discern if items are the same or different in their psychological significance for the particular ethnic group.

Issues such as the ones outlined above can play out in a discrepancy in the mental health services available to minority clients. In fact, some of the earlier research found that lower class or black individuals were more likely to be diagnosed as psychotic rather than neurotic (Rosen & Willis, 1973). Also, Shapiro (1975) states that whites are more likely to be diagnosed as having depressive psychosis while blacks will be labeled as schizophrenics because psychiatrists in the past were taught that black people do not suffer from depression. Even when whites are diagnosed as schizophrenics, they are usually subdiagnosed as reactive types, which gives them a good prognosis for recovery and enhances their chances for psychotherapy. Blacks are typically subdiagnosed as process or chronic schizophrenics, which implies a poor prognosis. More recent research indicates that many of the problems of the past are still in evidence. Allen and Majidi-Ahi (1983) indicate that there is bias towards sending blacks to behavioral rather than insight-oriented therapy. Sue and Zane (1987) indicate that

minorities have low utilization rates and high dropout rates compared to the majority culture. Rosenthal & Carty (1988) discuss the impediments that black and hispanic people have run into in the delivery of mental health services. Several of the problems outlined include excessive institutionalization, misdiagnosis of black and hispanic consumers, second-class services for minority consumers, and the mental health system's unfamiliarity with alternative support systems.

It is uncertain the degree to which viewpoints of white therapists are prejudicially distorted or accurate. Given this, it seems particularly important to understand how therapist perceptions and stereotypes can affect the therapeutic alliance. To address this need in early research, Yamamoto and his colleagues (1967) assessed the strength of white therapists' ethnocentric attitudes, revealing that those who maintained high levels of ethnocentrism engaged black patients for shorter treatment durations than did low ethnocentric therapists. Terestman, Miller, and Weber (1974), in a different approach, differentiated between therapists who were and were not effective at treating low socioeconomic status, minority patients and compared ratings of their psychotherapy skills. Supervisors gave "good" therapists higher marks for sensitivity and the ability to identify racial and socioeconomic class differences than "poor" therapists. Sue (1988) suggests that therapist biases concerning ethnic

minority clients reflect the nature of race relations in our society. Such biases can result in misdiagnoses, inadequate assessment, and biases in countertransference. Minrath (1985) argues that racial and ethnic stereotyping is a defensive maneuver used by patient and therapist to cope with the anxiety aroused by the interracial nature of the relationship. Jones (1982) in his study of psychotherapists' impressions of treatment outcome as a function of race found that white therapists generally rated their clients, and especially their black clients, as psychologically more impaired than did black therapists. Adjective descriptions revealed important differences in the perception of black and white clients by therapists of the two races. Contrary to expectation, there were no differences in psychotherapy outcome as a function of client-therapist racial match.

From the research findings, it appears that the race of the client can exert an effect on the therapeutic relationship, particularly in the earliest stages of treatment. When white therapists rely on biases or stereotypes when treating clients from minority cultures, this can result in negative effects such as premature termination and misdiagnoses.

Rater (therapist) variables

Perhaps the more one knows about the therapists making the judgments, the better one can understand their stereotypes. There are an inordinate number of therapist

variables which affect the treatment relationship. An adequate taxonomy of therapist variables must be able to distinguish between those that exist independently of and coincidentally to the treatment relationship and those that are specifically designed to have an impact on the treatment process. It is also important to be sensitive to how directly these variables can be observed. Beutler, Crago, and Arizmendi (1986) developed four quadrants of therapist characteristics. They described extratherapy characteristics as those that are assumed to exert an incidental effect on the therapy relationship while therapy-specific characteristics are those designed by the therapist's experience and training to facilitate positive change. As such, therapy-specific characteristics are assumed to be under the therapist's control while extratherapy variables represent less controllable and enduring traits. Externally observed characteristics require little inference from the defining observations. Inferred, internal characteristics are those that are used to imply some internal state of the therapist and thereby more difficult to observe and define. Beutler and his colleagues report that these are characteristics such as attitudes and values or expectations of the therapist. It is important to note that there is no clear dividing point between externally observed and inferred, internal therapist characteristics. For example, certain attitudes inherent to one's sex may be interpreted as mediating variables in order

to explain either a positive or negative finding deriving from a gender-related investigation. This study attempts to examine the relationship between "external" target variables and "external" characteristics of therapists and one aspect of their "inferred, internal" characteristics, i.e., stereotypes.

Therapist sex. Two decades of heightened sensitivity to sexism has stimulated active research into the effects of sex (e.g., Deaux, 1984) in psychotherapy. While Parloff, Waskow, and Wolfe (1978) reported three systematic studies on the effects of therapist sex on psychotherapy process and seven on psychotherapy outcome, the number of available studies has more than doubled over the past several years. Most of the research in this area employs naturalistic designs in which sex is explored as a variable ancillary to more systematically investigated characteristics or treatments. This limitation is compounded by the complexity with which sex interacts with variables such as environment (Bloom, Weigel, & Trautt, 1977), experience (Cartwright & Lerner, 1963) or type of population and problem (Bernstein & Figioli, 1983; Lee, Hallberg, Jones, & Haase, 1980).

In spite of such difficulties, the best controlled research investigations available consistently suggest that therapist sex exerts a modest effect on the selection of patients, the nature of the therapeutic process, and therapeutic change. For example, Jones and Zoppel (1982) compared therapy processes and outcomes among four groups of

contrasting patient-therapy sex combinations. Careful descriptions of therapists' experience levels and reasonable post hoc matching of the groups achieved a high level of sophistication for research in this area. Female therapists saw patients of both sexes as having more sexual and relationship problems than did male therapists and also rated their patients as more improved on 5 of 11 outcome measures. Male therapists, on the other hand, perceived male and female patients differently. They rated female patients as significantly less improved than male patients. Moreover, reports of the former clients generally agreed with those of their therapists, that is, similar sex dyads were rated as more helpful than opposite sex dyads. Fisher and Howard (1984), utilizing a long-term, accumulating data pool, examined changes in symptoms that accrued as a joint function of patient-therapist sex and the year in which the therapy was undertaken. The results suggested that simple sex matching exerted a rather direct influence on the outcome of studies conducted during the late 1960s. In the last decade, the amount of prior therapy and the nature of the issues under discussion have come to interact with sex match in rather complex ways. In other words, as attitudes toward sex roles have changed, the effect of therapist sex may be quite different depending upon the phase of therapy being observed. As sexual attitudes have become less stereotyped, sex seems to exert an increasingly complex or interactive effect on outcome.

In research studies about the relevance of therapist sex to assessment, duration of treatment, and satisfaction with treatment or its outcome, no clear, replicable results salient to decision making were provided (Mogul, 1982). No specific conclusions as to optimal patient-therapist matches on the basis of therapist sex appear warranted. Kaplan (1985) suggests that the question of therapist sex and its effect on therapy with women highlights an issue of therapist self-awareness and growth rather than one of the patient's selection process.

Davenport and Reims (1978) found that, of all the factors they investigated, only the clinicians' sex influenced their attitudes toward women's roles. Using a sample consisting of two groups of clinicians-in-training who differed with regard to the orientation of their training program, they found that the sex of the respondent did have a significant influence on clinicians' attitudes. No interaction between sex and theoretical orientation was reported, nor were the professional characteristics or practicum setting, marital status, age or number of years of experience statistically significant with regard to attitudes toward women. The authors found the total sample to have more contemporary than traditional attitudes, with the females' attitudes significantly more contemporary than those of the males. These results led the authors to speculate that although there is increased sensitivity to and awareness of gender stereotyping and attitudes toward

women compared to the findings of earlier research, there is continued evidence that this is less in males than females and still generally far from optimum. Brown and Hellinger (1975) found that female therapists are significantly more contemporary in their attitudes toward women than are male therapists. The finding that men are typically less informed than women was confirmed by Helwig (1976).

Overall, the current findings suggest that female therapists, first, and therapists of the patient's sex, second, facilitate treatment benefit, especially if these therapists present a nonstereotypic sexual viewpoint. Treatment outcome is less consistently affected by the therapist's sex and sexual-role identities.

Therapist age. There are two major methodological difficulties facing those who investigate the influence of therapist age. Age is often confounded with the therapist experience level and/or theoretical orientation. Since experience accumulates with age and since the theoretical philosophies and offerings emphasized by training programs have changed over the course of time, these potential influences should be considered in exploring the effects of therapist age on treatment outcome. Second, therapist age does not exert only a unidirectional effect. That is, an age difference of 15 years may exert a different effect when the therapist is the older member of the dyad than when the patient is the older member. Both actual and relative

differences between patients' and the therapists' ages should be taken into consideration.

In research on therapist age, samples representing a wide range of ages among both patients and therapists ideally would be investigated, statistically or methodologically controlling for the effect of experience and theoretical orientation. However, this degree of rigor has been difficult to accomplish in most research settings.

Luborsky and colleagues (1983) explored the contribution of patients' and therapists' actual age similarity to the quality of the treatment relationship. The findings revealed that age similarity was positively related to the development of a helping treatment relationship. An advantage in favor of patient and therapist age similarity has also been observed in some studies of relatively young patients. For example, adolescents have been found to prefer and attach most easily to age-similar counselors when discussing personal problems (Getz & Miles, 1978). To date, very little is known about either the role of therapist age or relative age similarity among patient samples of older adults. Preference surveys suggest that older adults perceive young therapists to be insufficiently wise and too immature to be maximally helpful (e.g., Donnan & Mitchell, 1979) but these preferences may be partially attenuated when the effects of therapist credibility and status are partialed out (e.g., Lasky & Salomone, 1977). These are interesting topics deserving of

additional consideration in view of the perspective differences that may color relationships between young therapists and more elderly patients. Confrontation with very elderly patients may either threaten or be of no interest to younger therapists (e.g., Lewis & Johansen, 1982). Martin and Prosen (1976) further suggest that communication in such dyads may be impaired because young therapists are still anticipating their future while older patients, themselves, may look at the future through a spectre of impending death and find solace in the past. Finally, young therapists have not experienced some of the processes of life that are relevant to older patients, and this may both impede the development of the relationship and retard psychotherapeutic change. In summary, it appears that as a unidirectional concept, therapist age exerts only a weak effect on treatment outcome.

Therapist race. In exploring the role of therapist ethnicity, problems arise both with adequate sampling and failure to control potentially confounding variables. With regard to the former, the assessment of treatment related improvements has been impaired by the frequent failure to consider all possible ethnic pairs. Confounding influences also derive from the failure to control or match patient groups on the basis of type or degree of disturbance, socioeconomic status, sex, and amount of therapy received. Since one is unable randomly to assign ethnicity, group comparison procedures with controlled assignment represent

the most rigorous investigations available. Jones (1978), for example, selected a sample of female patients and male therapists. In spite of the systematic sex confound, the black and white comparison groups were closely matched in an effort to control for the influence of socioeconomic background, age, and education. Jones observed that while psychotherapy processes were benefitted by similar ethnic pairs, neither dropout rates nor ratings of subjective improvement by the patients and therapists distinguished the various ethnic matchings. Among the most interesting findings, Jones noted that the quality of the treatment relationship varied as a joint function of the phase of treatment and the ethnic match of the participants.

With few exceptions, the findings of Jones are representative of most outcome research on therapist and client ethnicity (e.g., Barrett & Wright, 1984). In a study of how culture is considered in evaluations of psychopathology, Lopez and Hernandez (1986) found that respondents to a mail survey (respondents included licensed social workers, psychologists, and psychiatrists in California) reported that their attitudes and behavior represented a culturally sensitive position. For example, 83% of the sample indicated that they consider culture for most or all of their culturally different patients. As cited earlier, in his study addressing psychotherapists' impression of treatment outcome as a function of race, Jones (1982) found that white therapists generally rated their

clients, and especially their black clients, as psychologically more impaired than did black therapists. These data were obtained from therapists after termination. In his work addressing psychotherapeutic services for ethnic minorities, Sue (1988) posits that the research around this issue has often been confounded with moral and ethical issues involving the shortage of ethnic and bilingual therapists. He also notes that another problem is that treatment effectiveness and ethnicity cannot be addressed by asking simple questions. He argues further that ethnicity is in fact quite distal to treatment outcomes and that the task is to examine more proximal variables. His rationale for ineffectiveness of psychotherapy with ethnic minority clients is that these clients have a more difficult time than white clients in achieving good outcomes from treatment because of ethnic mismatches and therapist biases in treatment. It appears there are many confounding variables that need to be teased out before conclusions can be reached. Although it appears that services for minority clients have improved over time, the literature points to the importance of cultural considerations in treatment in order to address biases that appear still to exist.

Therapist experience. In a review of the literature on therapist experience level, Auerbach and Johnson (1977) concluded that experienced therapists are more active, self-revealing, and variable in their behavior, make more interpretations, and are less optimistic about therapy

outcomes. Chance (1959) hypothesized that inexperienced therapists may be more anxious, more eager to develop a formula, more in need of a stereotype than their experienced colleagues. As aforementioned, it is important to note that therapist experience levels are frequently confounded with levels of training. To examine this adequately it would be necessary to contrast therapists who are still in the process of being trained with fully trained therapists. The best investigations distinguish between the amount (number of years) and type (professional discipline) of training.

In an attempt to control some of these variables, Haccoun and Lavigueur (1979) defined contrasting experience levels on the basis of number of prior therapy cases seen rather than by the amount of training received. The results suggested that experienced therapists had greater tolerance for patient expressions of anger and tended to engage in less negative stereotyping of such patients than did inexperienced therapists. Stein and Lambert (1984) in an intensive meta-analysis of 27 selected studies observed that positive effects of experience were most likely to emerge 1) when the experience levels of contrasting groups of therapists were quite distinct, 2) among difficult patients, 3) when complex and intensive treatments were investigated, and 4) when the outcome variables either were assessed early in treatment or included dropout rates. In summary, there is the suggestion that therapist experience may facilitate treatment process; however, these effects do not readily

translate to assessments of outcome. One might infer from these data that more experienced psychotherapists are less likely to rely on stereotypes.

Therapist theoretical orientation. There are a great number of different theoretical schools now in existence. There are undoubtedly more similarities than differences among the activities of effective therapists from different schools (Fiedler, 1950). The key difference seems to be that therapists from different theoretical schools hold different expectations (Houts, 1984) and engage in interventions that are consistent with the philosophies expressed by those schools (Cross & Sheehan, 1982). Most reviewers conclude that there are few distinguishing psychotherapy outcomes among therapists from different schools (Luborsky, Singer, & Luborksy, 1975). For example, Brenner (1982) reports that a particular theoretical orientation and corresponding technique are not crucial to outcome. Instead Brenner, in a review of the literature in this area, found that the following characteristics were "essential" to effective therapy: empathy, composure, readiness to discuss everything, encouragement, and purposefulness, not theoretical orientation. The most extensive meta-analysis that had addressed this issue (Smith, Glass, & Miller, 1980) yielded few significant differences in effect sizes among schools. Cognitive and behavior therapies, however, produced the two highest effect sizes and had an impact on a broader range of problems than

the other four classes studied. Shapiro and Shapiro (1982) applied a meta-analysis to a select sample of 143 studies. The results were similar to those obtained earlier by Smith, et al. (1980). Nearly one standard deviation differentiated treated from untreated groups. Differences among treatment methods, however, accounted for only ten percent of the variance in effect size and indicated that most of the treatment effects were produced independently of the specific theory adopted. Nonetheless, cognitive and behaviorally oriented treatments continued to produce the largest effect sizes, though modestly and nonsignificantly so.

Observing the potential power of cognitive and behavioral therapies, Miller and Berman (1983) applied a meta-analysis to 48 select studies, comparing those approaches that combined cognitive and behavioral interventions to more standard cognitive interventions. The authors found no significant differences between these two approaches, suggesting that both treatments exert a relative consistent impact across a wide variety of problems, diagnostic categories, and types of measurement. It is also noteworthy that cognitive therapy has consistently been found to exert at least an effect equal to that of antidepressant medications (Watkins, 1984; Blackburn, Bishop, Glen, Whalley & Christie, 1981). It is important to note that little attention has been given to characteristics of patient groups, aside from their diagnostic identity.

In response to these concerns, increasing attention has been paid in recent years to the possibility that even though the average effects of different psychotherapies may be indistinguishable, patients with different characteristics may respond differentially to different treatment interventions. The methodological problems in this type of investigation are overwhelming. It would be necessary to define what the relevant patient dimensions are, but one must systematically control all concomitant and corollary variables at the same time that one assigns patients to different treatments on the basis of the relevant variables. In spite of these inordinate difficulties, most research on this issue has applied a correlational or post hoc methodology. For example, Snider (1979) asked therapists to describe the treatments of schizophrenic and neurotic patients. All therapists agreed that different interventions were required for the successful treatment of these two patient groups. Maintaining a specific therapeutic focus was targeted as significantly important for treating neurotics, while assuming a parental role was considered to be an important asset for working with schizophrenics. In general, it seems that theoretical orientation and technique are not crucial to outcome. More important than technique is the clinician's ability to express empathy, encouragement, openness, and purposefulness. Given this data, it seems that theoretical orientation as a variable would not be

predictive of stereotypes if one assumes a "good" therapist would possess the above-listed characteristics no matter his or her theoretical orientation.

Amount of contact with various categories of clients. According to Brigham (1971) familiarity with the ethnic group does appear to show a nonambiguous relationship to uniformity of stereotype. The familiarity-preference interaction was investigated by Taft (1959) who found a very high positive relationship (r=.92). Previous studies did not yield such striking results. As Scott (1965), Triandis and Vassilious (1967), and others have pointed out, the nature of the relationship would seem to depend upon the circumstances under which familiarity is acquired and the kind of interdependence that the groups maintain. Uniformity of stereotype seems to be positively related to familiarity with the object group, and traits attributed to one's own group, tend to be more favorable than traits applied to other groups. The relationship between familiarity (or degree of contact) and preference would seem to be dependent upon the circumstances under which the familiarity was achieved. It does seem in general, however, that familiarity might inhibit use of stereotypes. However, it is important to note the circumstances of the relationship.

Similarity between target and therapist

Target sex and rater (therapist) sex. In a controlled assignment study, Blase (1979) considered all possible sex

pairings and evaluated a diverse group of 40 psychiatric outpatients seen over the course of 10 treatment sessions. The results indicated that patients felt more satisfied at the end of treatment after having seen a therapist of their own sex. Few other outcome benefits of sex matching were observed.

The benefit of sex similarity has also been suggested by some naturalistic studies (e.g., Orlinsky & Howard, 1976). For example, Kirshner, Genack, and Hauser (1978) found that among patients seeking therapy at a university health service, female patients reported greater improvement than male patients, especially if seen by female therapists. In a similar correlational study that incorporated a population of clinical outpatients and highly experienced therapists. Kaschak (1978) found that same-sex dyads, especially those with female therapists, produced more favorable estimates of change than opposite-sex dyads.

In view of the foregoing findings, it is noteworthy that most comprehensive reviews have concluded that there are few observable effects of therapist sex or patient-therapist sex matching on treatment outcome (Cavenar & Werman, 1983; Mogul, 1982). Collectively, these findings suggest that, while similar sex matchings may exert a statistically significant effect on psychotherapy process, research methodologies must be rather rigorous and well defined in order to allow this relatively modest effect to emerge as outcome differences.

Target age and rater (therapist) age. Luborsky, Crits-Christoph, Alexander, Margolis, and Cohen (1983a) explored the contribution of patients' and therapists' actual age similarity to the quality of the treatment relationship. Like many studies in this area, age was considered as an ancillary variable and was inspected apart from the main objectives of the study. The findings revealed that age similarity was positively related to the development of a helping treatment relationship. Age similarity was also found to be significantly correlated with composite measures of treatment outcome (Morgan, Luborsky, Crits-Cristoph, Curtis, & Solomon, 1982).

Dembo, Ilkle, and Ciarlo (1983) also studied a large group of psychiatric outpatients and their therapists. Age similarity was one of several demographic variables naturalistically studied. Age difference did not exert a significant effect on treatment outcome as defined by emergency room visits, psychiatric admissions, clinician ratings, and patient ratings. The only significant effect of actual age differences was the observation that patients in the 18 to 30 year range whose therapists were of similar age reported less posttreatment psychological distress and isolation than did those patients whose therapists' ages were 10 or more years different from their own.

In one of the few matching studies of both actual and relative age differences, Karasu, Stein, and Charles (1979) compared 22 patients who were from 10 to 12 years younger

than their therapists. Although the findings cannot be directly generalized to older therapist groups, they nonetheless suggest that patients and therapists of similar ages engage in more productive treatment processes than those of different ages.

As aforementioned, little is known about either the role of therapist age or relative age similarity among patient samples of older adults. Donnan and Mitchell (1979) suggest that older adults perceive young therapists as less able to be maximally helpful to people of their age group.

In summary, it appears that age similarity may exert a modest effect on improvement. Given this, age similarity may play a significant role in determining gender stereotypes.

Target race and rater (therapist) race. It is well documented that the majority of therapists are white. Over the years it has been questioned as to what extent a minority client can be helped by a white clinician. Often the prevalent attitude from black clients has seemed to be one of "if you're not black, you can't understand me." Clinicians who accept this view, however, may be victims of having clients use this as an excuse for avoiding the work of the therapy. A subsequent failure to attempt to be helpful would only serve to further perpetuate this notion. To understand this dynamic, it would be helpful to ascertain the effect of racial similarity between the therapist and client on the therapeutic relationship.

The early literature, despite its limitations, seems to support clinical observations that racial differences have an inhibiting effect on psychotherapy. For example, Adams (1970) postulated that the white doctor and the black patient encounter each other in psychotherapy with a cultural background of preparedness for making racial distortions; each party brings to the relationship personal biases regarding race and racism. Jones and Jones (1970) argue that this dyad poses insoluble problems and that white therapists' efforts will in fact be destructive to black clients.

This issue has proponents on all sides. Schacter and Butts (1968) argue that the biracial dyad can have a catalytic effect upon the therapeutic process and in fact can lead to a more rapid unfolding of core problems. Friedman (1966) supports this latter position while calling for therapists to discard their theories and learn more about the culture of their clients. Regardless of which position one chooses to adopt, the fact remains that most therapists are white and at some point it may be necessary for them to work with a client from a cultural background very different from their own.

More recent research seems to indicate mixed results as well. Fry, Kopf, and Coe (1980) found that both type and appropriateness of counselors' responses were best with black/black and white/white dyads. As noted earlier, Jones (1978) observed that while psychotherapy processes were

benefitted by similar ethnic pairs, neither dropout rates nor ratings of subjective improvement by the patients and therapists distinguished the various ethnic matchings. With few exceptions, the findings of Jones are representative of most outcome research on therapist and patient ethnicity (e.g., Barrett & Wright, 1984). There has not been a consistent finding of substantial differences in treatment outcome as a function of patient and therapist ethnic matches. When differences have emerged, they suggest that dropout rates (e.g., Terrell & Terrell, 1984) and lack of sensitivity to ethnic issues (e.g., Turner & Armstrong, 1981) characterize ethnically dissimilar treatment dyads. Nevertheless, similar ethnic matches have been found to characterize patients' preferences and to enhance patients' participation in the early stages of treatment (Grantham, 1973; Proctor & Rosen, 1981).

In an article addressing theoretical consideration of the effects of race on counseling, Helms (1984) describes four possible types of relationships between black and white dyads. There can be parallel, crossed, progressive or regressive relationships. A parallel relationship is one where counselor and client belong to the same stage of racial consciousness and share the same attitudes about blacks and whites. A crossed relationship is one where the counselor and client belong to opposite stages, defined as having opposing attitudes about both black and white persons. A progressive relationship is one where the

counselor's stage is at least one stage more advanced than the client's, and finally a regressive relationship is one where the client's stage of development is at least one stage more advanced than the counselor's. The above definitions apply when client and counselor are of different races. The specific implications of the parallel and crossed dyads will probably differ depending on whether the counselor and/or clients are black or white and whether the counseling is intra- or cross-racial. By identifying the counselor and client's racial consciousness stages, it should be possible to make predictions about the quality of their counseling relationship as well as possible counseling outcomes. The above suggest the value of attitudinal flexibility and of being attuned to ethnic differences in promoting treatment outcome. Although ethnic similarity, at least initially, may exert a positive effect on premature termination, further exploration of this possibility is needed along with efforts to reveal the attitudinal characteristics of not only therapists but also clients that may determine this effect.

Note that in the present study all respondents were white. Therefore, specific tests of the effect of therapist's race cannot be carried out.

Summary

All of the above seems to suggest that particular therapist characteristics may have some impact on therapy process and outcome. It is unclear what this impact may be

in many instances; therefore, it is important to examine the relationship between these characteristics and therapists' stereotypes. For example, can we begin to understand based on knowledge on the age, sex, experience level, or theoretical orientation of a therapist what his or her gender stereotypes may be? It could be postulated that these stereotypes may be just a sampling of the many variables affecting the success of the therapeutic alliance thus possibly resulting in premature termination, biased diagnoses, and therapy outcome.

Turner and Turner (1987) found that gender stereotypes do exist and in fact vary by age and race. The current study looks at the characteristics of the respondents in the Turner investigation. The information available on the respondents in this study includes age, race, year of highest degree, whether active in clinical practice, clinical orientation, percentage of clients that are male and female that belong to different ethnicities, and that are of different ages. For the purpose of this study, it is not possible to examine more specifically the dynamics of the therapeutic relationship, but instead the relationship between several of the above listed therapist characteristics and therapists' stereotypes are considered.

Given the findings in the literature, the following hypotheses were made:

1. It was predicted that theoretical orientation would not be significant in predicting gender stereotypes.

2. It was predicted that years of clinical experience (as measured by year of highest degree) would be significant in predicting stereotypes in clinicians; that is, experienced clinicians would rate targets more positively than less experienced clinicians.

3. It was predicted that the amount of contact a therapist has with a particular client group would be significant in predicting stereotypes; the greater the contact, the more positive the ratings of the targets.

4. It was predicted that the degree of similarity between therapist and client would be significant in predicting stereotypes in clinicians; the greater the similarity, the more positive the ratings of the targets.

CHAPTER 2

METHOD

Sample

This study utilizes the data collected by Turner and Turner (1987) in their study on gender stereotypes for men and women varying in age and race. For this study, surveys were mailed to 1200 randomly selected psychotherapists listed in the 1985 National Register of Health Care Providers in Psychology. There were 554 surveys returned which were deemed usable indicating a response rate of 46%. Ninety-six percent of the respondents were white and 74% were male. Only 1% of the respondents were black. The mean age was 51 with a range from 27 to 83. All but 3% of the sample had doctoral degrees (95% had Ph.D.s). On the average, 87% of the respondent's clients were white and 55% were female. Thirty-five percent reported seeing at least one client aged 65-69 and 20% reported seeing at least one client over the age of 69 (Turner & Turner, 1987).

Procedure

The data were collected in 1986. At that time, surveys which included the Bem Sex Role Inventory were mailed to the total sample. Respondents were asked to rate a "mature, healthy, socially competent" individual (cf. the method established by Broverman, et al., 1970 which used the questionnaire developed by Rosenkrantz, et al., 1968). The target description used in this study is considered an approximation of the type of "ideal" target description

often used in research on stereotypes. This type of ideal target description has been found to reduce stereotypical differences in ratings for a variety of paired targets (e.g., Luszcz, 1985-86). Given this, the method utilized in this study allows for a conservative assessment of differences in stereotypes for the targets rated.

In this study, unless otherwise specified, targets were understood or assumed to be white. It has been found that unless it is otherwise specified or the rater is nonwhite, in white America, targets are understood to be white (Turner and Turner, 1974). In their study, Turner and Turner (1974) found that without exception, white respondents when asked to rate "most men" and "most women" using a semantic differential replied that they had whites in mind. Given this data, it seems safe to assume that white respondents had white targets in mind when rating race-unspecified targets.

Respondents were randomly assigned to one of 18 target descriptor groups (a black or race unspecified man, woman or adult in their late 20s, late 40s or late 60s). There was not a significantly different response rate for age of target, race of target, or sex of target conditions ($p > .05$).

Instrument

The instrument used was one constructed by Bem (1974) to measure socially desirable personality attributes of masculinity and femininity as numerical dimensions. It

contains 20 masculine-associated, 20 feminine-associated, and 20 supposedly gender-neutral traits. Each item is scored on a seven point scale, ranging from "never or almost never true" (scored 1) through "occasionally true" (scored 4) to "always or almost always true" (scored 7).

All 554 respondents' masculinity and femininity subscale items were factor analyzed. Four statistically independent factors were found (see Table 1). The factors that were found were quite similar to those reported in earlier studies using self-descriptions (Gaudreau, 1977; Ruch, 1984). The first factor was termed Nurturant. It contained 15 of the femininity subscale traits where the highest loadings appeared for compassionate, tender, gentle, sensitive to the needs of others, sympathetic, understanding, and warm. The other feminine scale items did not load highly on this factor. The items which did not load significantly on this scale were feminine, gullible, shy, flatterable, and childlike. The second factor was called Agentic. It contains all the masculine subscale items except for the item masculine. Factor three was termed Self-Governing. These are the feminine subscale traits which have been found to be less socially desirable (Ruch, 1984). This factor loads appreciably on items which describe someone who is not gullible, not shy, not flatterable, not childlike, and who is also autonomous. Higher scores on this factor suggest someone is not vulnerable to being controlled or manipulated by others.

These traits are viewed as masculine-associated. The fourth factor is assumed to tap physical and sexual characteristics related to gender. This factor was termed Potent. The support for this interpretation lies in the fact that the only other item which had an appreciable loading on this factor was athletic. Also, in semantic differential research, the single terms masculine and feminine consistently load high on the Potency factor and not on other major semantic differential factors, Evaluation and Activity (cf. Ashmore, Del Boca, & Wohlers, 1986). Potency includes dimensions such as hard-soft and strong-weak (Ashmore, Del Boca, & Wohlers, 1986).

Based on the factor analysis, scale scores were created for each subject for each factor. That is, items with high loadings were summed for each subject. The measure of the first three dependent variables used in this analysis was the mean of each response rating on the traits that loaded over .39 on the Nurturant, Agentic and Self-Governing factors. Rather than sum items in the Potent factor, the items masculine and feminine were analyzed separately. The single items masculine and feminine do not appear to tap psychological trait dimensions represented by the other variables Nurturant, Agentic and Self-Governing scales and were therefore not included in any further analyses.

In the present study, it is assumed that all of the dependent measures are positively valued traits and that any score significantly greater than another indicates a more

positive evaluation of a particular group. A lower score is indicative of a target group (as compared to another target group) lacking in the positively valued attribute being measured.

Nonwhite respondents were excluded from the analyses presented herein due to the small number of respondents (n = 25). As indicated earlier, the Turner and Turner (1974) study found that minority respondents viewed race-unspecified targets as members of their own racial or ethnic group, just as whites perceived targets as white. Also excluded from the analyses were those respondents who were asked to rate "adult" targets. For simplicity, only those respondents rating male and female targets were included in the analyses presented herein (N = 360).

Attached to the Bem Sex Role Inventory was a survey eliciting information on therapist characteristics. The information provided included year of highest degree, theoretical orientation and information on the therapist's client population (percentage of male, female, black, and old clients). See the Appendix for a copy of the study instruments.

The categories for each variable were derived in the following manner. Year of highest degree was divided into three categories: 1925-1971 (n = 117), 1965-1971 (n = 106), and 1972-1986 (n = 134). Each category contained approximately one-third of the sample.

For theoretical orientation, an attempt was made to group categories which were of a similar theoretical framework while at the same time keeping the size of the grouping as equivalent as possible. The first category contained respondents who identified themselves as behavioral, rational-emotive, and cognitive psychotherapists (n = 55). The second category included client-centered, interpersonal, and dynamic psychotherapists (n = 102). The third category encompassed the eclectic clinicians (n = 156) and the final category included systems therapists and clinicians who identified themselves as "other" (n = 47).

For amount of contact with various categories of clients, each independent variable (percent female clients, percent old clients, percent black clients) was divided into three categories. For each grouping, an attempt was made to keep the categories as equivalent as possible in size. It is also important to note that for these analyses only those respondents who rated female, old, and black targets were included. For the variable, percent of female clients, the first category (for those who rated female targets only) included those clinicians with between one and 49 percent female clients in their clinical practices (n = 31). The second category included clinicians with between 50 and 60 percent female clients in their clinical practices (n = 89). Finally, the third category was for those clinicians who reported that there were over 60 percent females in their clinical practices (n = 53).

For the variable, percent of old clients, the first category (for those who rated old targets only) included those clinicians with no old clients (n = 65). The second category included clinicians with between one and 25 percent old clients in their clinical practices (n = 24). Finally, the third category was for those clinicians who reported that there were greater than 26 percent old clients in their clinical practices (n = 22).

For the variable, percent of black clients, the first category (for those who rated black clients only) included those clinicians with no black clients (n = 45). The second category included clinicians with between one and ten percent black clients in their clinical practices (n = 83). Finally, the third category was for those clinicians was for those clinicians who reported that there were greater than ten percent black clients in their clinical practices (n = 32).

Table 1

Bem Sex-Role Inventory Principle Component Factor Analysis with Varimax Rotations

	FACTOR 1 NURTURANT	FACTOR 2 AGENTIC	FACTOR 3 SELF-GOVERNING	FACTOR 4 POTENT
COMPASSIONATE	.80989			
TENDER	.79834			
GENTLE	.78170			
SENSITIVE TO THE NEEDS OF OTHERS	.77994			
SYMPATHETIC	.76369			
UNDERSTANDING	.76163			
WARM	.75199			
AFFECTIONATE	.67025			
LOYAL	.59731			
LOVES CHILDREN	.57179			
EAGER TO SOOTHE HURT FEELINGS	.56966			
CHEERFUL	.50830			
DOES NOT USE HARSH LANGUAGE	.44712			
SOFT-SPOKEN	.43313			
YIELDING	.41577			
ASSERTIVE		.72470		
FORCEFUL		.70783		
ACT AS A LEADER		.69425		
AMBITIOUS		.67563		
WILLING TO TAKE A STAND		.65812		
WILLING TO TAKE RISKS		.64693		
COMPETITIVE		.63924		
INDEPENDENT		.62495	.41608	
DOMINANT		.61774		
HAS LEADERSHIP ABILITIES		.61069		
DECISIVE		.59176		
STRONG PERSONALITY		.58915		

continued next page

	FACTOR 1 NURTURANT	FACTOR 2 AGENTIC	FACTOR 3 SELF-GOVERNING	FACTOR 4 POTENT
SELF-SUFFICIENT		.58490	.41133	
INDIVIDUALISTIC		.55304		
ANALYTICAL		.54750		
DEFENDS OWN BELIEFS		.54238		
SELF-RELIANT		.53447	.40925	
ATHLETIC		.51059		
AGGRESSIVE		.46417		
GULLIBLE			-.75275	
SHY			-.60621	
FLATTERABLE			-.56702	
CHILDLIKE			-.56213	
MASCULINE				.82077
FEMININE				-.75492

CHAPTER 3

RESULTS

Since the primary purpose of this investigation was to test the effects of the respondent variables, the findings which involve such variables will be the primary focus. Analyses of variance were performed on each of the three measures (Nurturant, Agentic and Self-Governing) by therapist theoretical orientation, year highest degree received, similarity between therapist and target in age and sex, amount of contact with various categories of clients as well as target age, target race, and target sex. The results of these analyses are listed in Tables 2 through 14.

Hypothesis 1 - Theoretical Orientation

Nurturant

Theoretical orientation did not yield a significant main effect on the Nurturant scale score (see Table 2). There were no main or interaction effects. Although the findings were not statistically significant, inspection of the group means indicates that targets were viewed as most "nurturant" by clinicians who were identified in the category "dynamic" ($\underline{M}$ = 4.95) while those who were classified in the category "behavioral-rational" viewed targets as least "nurturant" ($\underline{M}$ = 4.78). Clinicians identified as "other" ($\underline{M}$ = 4.92) and "eclectic" ($\underline{M}$ = 4.87) fall in between respectively (see Table 2).

A tendency toward significance for the main effect appeared for sex of target in which female targets were

viewed as more "nurturant" than male targets (see Table 2). The tendency for main effect for sex reappeared for each analysis of a therapist variable on the Nurturant scale score. Therefore, it will not be reported in the remaining results. There was not a significant orientation by target sex interaction. Across all specialties, males were viewed as less nurturant than females. Inspection of the cell means indicates that among male targets, dynamic clinicians perceived those targets as most "nurturant" ($\underline{M}$ = 4.96) while behavior-rational therapists saw male targets as least "nurturant" ($\underline{M}$ = 4.70). For female targets, clinicians identified as behavioral-rational viewed them as least "nurturant" while those identified as "other" saw females as most nurturant.

There was not a significant main effect for target age nor was there a significant interaction effect between orientation and target age. Although no statistically significant results appeared, review of the group means indicates that middle-aged ($\underline{M}$ = 4.92) and old targets ($\underline{M}$ = 4.91) were viewed as more nurturant than young targets ($\underline{M}$ = 4.82). Looking at the interaction between orientation and target age, it was found that among young targets, behavioral-rational therapists found this group least nurturant ($\underline{M}$ = 4.51) while clinicians identified as dynamic ($\underline{M}$ = 4.98) found this group most nurturant. For middle-aged targets, eclectic therapists found this group most nurturant ($\underline{M}$ = 4.96) while dynamic therapists found this group least

nurturant ($\underline{M}$ = 4.86). Finally among the old targets, therapists identified as other found this group most nurturant ($\underline{M}$ = 5.03) while eclectic therapists found this group least nurturant ($\underline{M}$ = 4.80). Behavioral-rational, dynamic and "other" clinicians found the young targets least nurturant and the old targets most nurturant. For eclectic therapists, the young and old target groups had virtually identical means with middle-aged targets being viewed as most nurturant.

No significant main effect for target race or the target race by orientation interaction was found. Inspection of the means indicates that white targets ($\underline{M}$ = 4.90) were seen as slightly more nurturant than black targets ($\underline{M}$ = 4.86). When the race by orientation interaction is examined, whites were seen as more nurturant than blacks across all specialties. Among whites, dynamic therapists saw this group as most nurturant and behavioral-rational therapists saw this group as least nurturant. Among black targets, the same pattern emerged. It is important to note that these differences are not statistically significant.

For the scale score "Nurturant", the hypothesis is supported that there is not a significant relationship between theoretical orientation and therapists' gender stereotypes.

Agentic

Theoretical orientation did yield a significant main effect on the agentic scale score [($F(3, 528) = 3.206$, $p < .023$)]. This can be seen by referring to Table 2.

Inspection of the means indicates that behavioral-rational clinicians saw targets as least agentic ($M = 4.61$) while dynamic and eclectic therapists saw targets as most agentic ($M = 4.83$). See Table 3.

There was also a significant main effect for sex of target in which males were seen as more agentic than females (see Table 2). There was not a significant orientation by target sex interaction. Across all orientations, males were seen as more agentic than females. Among males, dynamic clinicians saw this group as most agentic ($M = 4.98$) while behavioral-rational clinicians as the least agentic ($M = 4.74$). With females, the same pattern emerged (see Table 3).

There was a significant main effect for age found in which young targets were seen as more agentic than middle-aged and old targets; the old being viewed as the least agentic. There was not a significant orientation by age interaction. Across all orientations, the young were seen as more agentic than the middle-aged and old. Among young targets, dynamic clinicians saw this group as most agentic ($M = 5.02$) while behavioral-rational therapists saw this group as least agentic ($M = 4.84$). Among middle-aged targets, behavioral-rational clinicians saw this group as

least agentic (M = 4.77) while dynamic therapists saw this group as most agentic (M = 4.98). Finally across old targets, eclectic and dynamic therapists saw this group as most agentic (M = 4.59) while behavioral-rational therapists saw this group as least agentic (M = 4.27).

It is important to note that the main effect for sex of target and age of target on the Agentic scale score reappears for each analysis of a therapist variable. Therefore, it will not be reported in the remaining results.

There was not a main effect indicated for race. There was a significant target age by target race interaction where young blacks were seen as most agentic while old black targets were seen as the least agentic. There was no orientation by race interaction. Inspection of the means indicates that behavioral-rational therapists and therapists identified as "other" found white targets more agentic than black targets while dynamic and eclectic therapists found black targets more agentic than white targets.

For the scale score "Agentic", the hypothesis is not supported.

Self-Governing

Theoretical orientation did not yield a significant main effect on the Self-Governing scale score (see Table 2). Although this finding is not statistically significant, inspection of the means indicates that dynamic and eclectic clinicians found targets the most self-governing while

behavioral-rational therapists found targets least self-governing.

There was a significant main effect for age on this scale score with middle-aged targets being viewed as the most self-governing and the old rated as the least self-governing (see Tables 2 and 3). There were no other main or interaction effects indicated. It is important to note that the main effect for age of target on the Self-Governing scale score reappears for each analysis of a therapist variable and therefore will not be reported in remaining results.

On this scale score, the hypothesis is supported that there is not a significant relationship between theoretical orientation and clinicians' gender stereotypes.

In summary, for those scale scores that tap into "feminine" characteristics (nurturant) and masculine characteristics associated with autonomy, freedom from manipulation, etc. (self-governing), the hypothesis was supported. There appears not to be a significant relationship between clinicians' theoretical orientation and their gender stereotypes. However, for the scale score that taps into "masculine" characteristics associated with agency (agentic), the hypothesis was not supported. There seems to be a significant relationship between theoretical orientation and gender stereotypes.

Hypothesis 2 - Years in Clinical Practice

Years in clinical practice was measured by the year the clinician received his or her highest degree. As noted earlier, this may also relate to the age of the clinician. Initial analyses focused on age of therapist, divided into three equal-sized age groups. When age of therapist was related to the dependent variables, no main effects with any of the target variables appeared. Therefore, subsequent analyses focused on years of clinical experience. This category was divided into three categories: 1. 1925-1964, 2. 1965-1971, 3. 1972-1986. In the following discussion, clinicians in the first category was be called "most experienced", while those in the second category will be labeled "moderately experienced" and those in the third group will be called "least experienced."

Nurturant

The analysis of variance performed on the scale score "Nurturant" for the variable year degree received did not yield a significant main effect. Although this finding was not statistically significant, inspection of the means reveals that clinicians who received degrees between 1925 and 1964 (or "most experienced") therapists viewed targets as most nurturant ($\underline{M}$ = 4.91). Those clinicians who received their degrees between 1965-1971 and 1972-1986 or moderately and least experienced therapists saw targets as slightly less nurturant ($\underline{M}$= 4.85 and $\underline{M}$ = 4.88 respectively)(see Tables 4 and 5).

There were no significant interaction effects indicated. On the scale score Nurturant, the hypothesis was not supported that there would be a significant relationship between years in clinical practice and clinician's gender stereotypes.

Agentic

Year degree received did not yield a significant main effect on the Agentic scale score. Although this result was not statistically significant, review of the means indicates that those with a moderate level of experience saw targets as most agentic (M = 4.84) while those with the most and the least experience followed (M = 4.82 and M = 4.80 respectively)(see Tables 4 and 5).

No significant interaction effects were indicated. On the scale score Agentic, the hypothesis was not supported that years in clinical practice would yield a significant relationship with clinician's gender stereotypes.

Self-Governing

On the Self-Governing scale score, year degree received did not yield a significant main effect. Although this result was not statistically significant, inspection of the means indicates that moderately experienced clinicians saw targets as most agentic (M=4.93) with most and least experienced clinicians having virtually identical means (M=4.87 and M=4.85 respectively)(see Tables 4 and 5).

There were no significant interaction effects. However, there was a tendency toward significance on the

three-way interaction between year degree, target sex and target age (see Table 5). Inspection of the means indicates that among young targets, female targets were seen as more self governing than male targets by moderately and least experienced therapists while the most experienced clinicians saw males as more self governing than females. For middle-aged targets, those clinicians with the most and least years in clinical practice saw females as more self governing while moderately experienced clinicians saw males as more self governing. For old targets, moderately and least experienced clinicians saw male targets as more self governing than female targets while those clinicians with the most experience saw females as more self governing than males.

For young male targets, moderately experienced clinicians saw this group as most self governing ($\underline{M}$ = 5.09) while those with the least experience saw this group as least self governing ($\underline{M}$ = 4.57). For female targets, again moderately experienced clinicians saw this group as most self governing ($\underline{M}$ = 5.11) with most experienced clinicians viewing this group as least self governing ($\underline{M}$ = 4.74).

For middle-aged male targets, all the means were virtually identical with moderately experienced clinicians seeing this group as most self governing ($\underline{M}$ = 4.98) and those with the least and most experience having identical means ($\underline{M}$ = 4.95). For females, the same pattern emerged.

For old male targets, those clinicians with the least experience saw this group as most self governing ($\underline{M}$ = 5.03) while those with the most experience saw this group as least self governing ($\underline{M}$ = 4.77). For female targets, those with the most experience saw this group as most self governing ($\underline{M}$ = 4.84) while those with the least experience saw this group as least self governing ($\underline{M}$ = 4.59).

In summary, the hypothesis that years in clinical practice would have a significant relationship with clinician's gender stereotypes was not supported on any of the scale scores.

Hypothesis 3 - Percentage Client Population

To investigate the percentage of clinicians' client population, each category (percentage female clients, percentage old clients, and percentage black clients) was divided into three categories. For percentage female clients, the first category designated those clinicians with up to 49% female clients. The second category designated those with 50-60% female clients and the third category covered those with 60-99% female clients. As noted earlier, only respondents who rated female targets were included in these analyses. The percentage old clients first category included those clinicians with no old clients. Category two was for those clinicians with 1-25% old clients and the final or third category was for those clinicians with 26% and above old clients. Only respondents who rated targets in their late 60s were included in these analyses. Finally,

for percentage black clients, category one designated those therapists with no black clients while category two included those with 1-10% black clients. Category three covered those clinicians with more than 10% black clients. Only respondents who rated black targets were included in these analyses.

Nurturant

Percentage female clients. There was not a significant main effect for percentage female clients on the nurturant scale score. Although not significant, inspection of the means indicates that clinicians with the lowest percentage of female clients saw female targets as most nurturant (M = 5.02) while those with 50-60% female clients saw female targets as least nurturant (M = 4.90) (see Tables 6 and 7).

There were no significant interaction effects.

Percentage old clients. Percentage of old clients did not yield a significant main effect. Although this result was not statistically significant, inspection of the means shows that clinicians with more than 26% old clients saw old targets as most nurturant (M = 4.97) while those with no old clients saw old targets as least nurturant (M = 4.88) (see Tables 8 and 9).

There were no significant interaction effects.

Percentage black clients. Percentage of black clients did not yield a significant main effect on the nurturant scale score. Inspection of the means indicates that those clinicians with greater than 10% black clients saw black

targets as most nurturant (M = 4.95) while clinicians with no black clients and 1-10% black clients saw black targets as least nurturant (M = 4.82 and M = 4.83 respectively) (see Tables 10 and 11).

There were no significant interaction effects indicated. On the scale score Nurturant, the hypothesis was not supported that there would be a significant relationship between percentage of a particular client population and clinician's gender stereotypes.

Agentic

Percentage female clients. There was not a significant main effect for percentage of female clients on the agentic scale score. Although this result was not significant, inspection of the means indicates those clinicians with over 61% female clients saw female targets as least agentic (M = 4.69) while those with fewest female clients saw female targets as most agentic (M = 4.82). There were no significant interaction effects.

Percentage old clients. Percentage of old clients did not yield a significant main effect on the agentic scale score. However there was a tendency toward significance. Inspection of the means reveals that clinicians with greater than 26% old clients saw old targets as most agentic (M = 4.79) while those with no old clients saw old targets as least agentic (M = 4.42). Clinicians with 1-25% older clients had a mean of 4.63 (see Tables 8 and 9). The Student-Newman-Keuls procedure performed on the scores

indicated that those clinicians with greater than 26% old clients and those clinicians with no old clients were significantly different ($p < .05$). There were no significant interaction effects.

Percentage black clients. On the agentic scale score, percentage of black clients did not yield a significant main effect. Review of the means indicates that those clinicians with 1-10% black clients saw black targets as most agentic ($M = 4.88$) while those respondents with no black clients saw black targets as least agentic ($M = 4.81$) (see Tables 10 and 11).

There was a significant interaction effect between percentage of black clients and target sex [(F (2, 159) = 3.257, $p < .041$)] (see Table 12). Inspection of the means indicates that the greater the percentage of black clients the more likely was the therapist to rate black male targets as more agentic. The inverse was true for black female targets; the greater the percentage of black clients, the more likely was the therapist to rate black female targets as less agentic (see Tables 11 and 13). T-test analyses using separate variance estimates were used to assess direction and meaning of the effects. T-tests performed on each percentage black clients and target sex group indicated that clinicians with greater than 10% black clients perceived black male targets as significantly more agentic than black female targets [($t = 2.20$, $p < .036$)] (see Table 13).

In summary, for the scale score Agentic, there was partial support for the hypothesis. For percentage of old clients, there appears to be a trend toward a significant relationship between respondent's client population and their gender stereotypes. Also, a significant interaction was indicated between percentage of black clients and target sex.

Self-Governing

Percentage female clients. There was not a significant main effect on the self governing scale score for percentage of female clients. Although this result was not statistically significant, inspection of the means reveals that clinicians with 1-49% female clients saw female targets as most self governing ($\underline{M}$ = 4.92) while those with over 60% female clients saw targets as least self governing ($\underline{M}$ = 4.77) (see Tables 7 and 8).

There were no significant interaction effects.

Percentage old clients. There was not a significant main effect on the self governing scale score found for percentage of old clients. Although not statistically significant, inspection of the means reveals that clinicians with 1-25% old clients saw old targets as most self governing ($\underline{M}$ = 4.86) while those with no old clients saw old targets as least self governing ($\underline{M}$ = 4.66) (see Tables 9 and 10). There were no significant interaction effects.

Percentage black clients. There was not a significant main effect on the self- governing scale score for

percentage of black clients. Although this result was not statistically significant, inspection of the means indicates that those clinicians with 1-10% black clients saw targets as most self governing ($\underline{M}$ = 4.95) while those with no black clients saw targets as least self-governing ($\underline{M}$ = 4.84) (see Tables 11 and 12).

There were no significant interaction effects. However, there was a tendency toward significance for the percentage of black clients by target age interaction (see Table 10). Inspection of the means indicates that for young black targets, clinicians with 1-10% black clients saw this group as most self governing ($\underline{M}$ = 5.09). For middle-aged black targets, clinicians with greater than 10% black clients saw this group as most self governing ($\underline{M}$ = 5.01). Finally, those clinicians with no black clients, saw young black targets as most self governing ($\underline{M}$ = 4.97).

In summary on the self governing scale score, the hypothesis was not supported.

Overall, there was limited support for the hypothesis on the agentic scale score in the percentage of old clients category and percentage of black clients categories.

Hypothesis 4 - Similarity between Respondent and Target

Similarity is measured by the number of characteristics a respondent has in common with his or her target. The range can be from zero (or no characteristics in common) to three (or all characteristics in common). For example, a young white male would have no characteristics in common or

zero similarity with a target described as a black female in her late 60s while the same young white male would have all characteristics or three degrees of similarity with a target described as a white male in his late 20s. In light of the fact that the variable "similarity" is based upon target sex, target age and target race, there is an overlap of the variance. Therefore, it is inappropriate to include those variables (target sex, target age, and target race) in an analysis of variance that includes the variable "similarity", and one-way analyses of variance were done with similarity as the single variable.

Nurturant

The one-way analysis of variance performed on the scale score "Nurturant" for the variable similarity (degree of similarity with target) did not yield a significant main effect (see Table 14). Although this finding was not statistically significant, inspection of the group means reveals that clinicians with the least degree of similarity with a target ($\underline{M}$ = 4.95) saw targets as most nurturant while those with middle (1 and 2) degrees of similarity saw targets as least nurturant ($\underline{M}$ = 4.88).

On the scale score Nurturant, the hypothesis was not supported that there would be a significant relationship between the degree of similarity with targets and therapists gender stereotypes.

Agentic

Similarity did yield a significant main effect on the Agentic scale score [(F (3,262) = 3.461, p < .017). This can be understood by referring to Table 14. Inspection of the means indicates that clinicians with the least similarity with their targets (M = 4.43) saw targets as least agentic while those with the greatest degree of similarity (2 and 3) viewed targets as most agentic (M = 4.82 and M = 4.83 respectively).

On this scale score, the hypothesis is supported that there is a significant relationship between degree of similarity with targets and gender stereotypes.

Self-Governing

There was not a significant main effect found on the self governing scale score (see Table 14). Although this result was not statistically significant, inspection of the group means suggests a slight curvilinear relationship. Clinicians with the least degree of similarity and those with the most similarity with targets have identical cell means (M = 4.73).

The hypothesis is not supported on the self governing scale score.

In summary, it appears that on the nurturant and self governing scale scores, the hypothesis was not supported. There does not appear to be a significant relationship between degree of similarity between target and respondent and respondent's gender stereotypes on these scale scores.

On the scale score that taps into masculine-associated characteristics related to agency, the hypothesis was supported. Those clinicians with the highest degree of similarity saw targets as more agentic than those with the lowest degree of similarity. A significant relationship was found between the degree of similarity between target and clinician and their gender stereotypes.

Table 2

Analyses of Variance on the Scale Scores by Sex, Age, Race of Target and Respondents' Theoretical Orientation

Effect	Scale Scores		
	Nurturant	Agentic	Self-Governing
Sex of Target (ST)	2.658*	3.494**	.187
Age of Target (AT)	1.604	28.634****	4.195**
Race of Target (RT)	.491	.149	.012
Theoretical Orientation (TO)	1.439	3.206**	1.107
ST x AT	.365	.427	.956
ST x RT	.401	1.806	1.640
ST x TO	.847	.644	.820
AT x RT	1.502	6.121***	1.907
AT x TO	1.563	.585	1.060
RT x TO	.417	1.344	1.342

* p<.10 **p<.05 ***p<.01 ****p<.001

Table 3

Means on Scale Scores by Sex, Age, and Race of Target and Respondents' Theoretical Orientation

		N	Nurturant	Agentic	Self-Governing
Target Sex	Male	182	4.80	4.89	4.89
	Female	178	4.95	4.75	4.85
Target Age	Young	114	4.82	4.96	4.87
	Middle	127	4.92	4.89	4.95
	Old	116	4.91	4.51	4.77
Target Race	White	198	4.90	4.79	4.85
	Black	159	4.86	4.80	4.87
Orientation	Behav-Rat	55	4.78	4.61	4.77
	Dynamic	102	4.95	4.83	4.89
	Eclectic	156	4.87	4.83	4.89
	Other	47	4.92	4.79	4.82

Table 4

Analyses of Variance on the Scale Scores by Sex, Age, Race of Target and Year Highest Degree Received by Respondent

Effect	Scale Scores		
	Nurturant	Agentic	Self-Governing
Sex of Target (ST)	5.080**	3.376	.122
Age of Target (AT)	.929	21.286****	3.359**
Race of Target (RT)	.662	.301	.862
Year Degree (YD)	.280	.143	.736
ST x AT	.094	.872	1.273
ST x RT	1.636	1.971	.962
ST x YD	.683	.832	.142
AT x RT	2.312	.513	.230
AT x YD	.224	1.384	1.400
RT x YD	.985	.151	.059
YD x ST x AT	1.200	.710	2.370*
YD x ST x RT	.528	.673	.013
YD x AT x RT	.726	.299	.592
ST x AT x RT	.537	.323	.128

* p<.10 ** p<.05 ***p<.01 ****p<.001

Table 5

Means on Scale Scores by Sex, Age, Race of Target and Year of Highest Degree Received by Respondent

		Scale Scores			
		N	Nurturant	Agentic	Self-Governing
Target Sex	Male	181	4.80	4.89	4.90
	Female	176	4.96	4.75	4.86
Target Age	Young	114	4.81	5.00	4.91
	Middle	127	4.92	4.93	4.95
	Old	116	4.90	4.53	4.77
Target Race	White	198	4.90	4.80	4.85
	Black	159	4.85	4.85	4.91
Year Degree	1925-1964	117	4.91	4.82	4.87
	1965-1971	106	4.85	4.84	4.93
	1972-1986	134	4.88	4.80	4.85

Table 6

Analyses of Variance on the Scale Scores by Age and Race of Target and Respondents' Percentage of Female Clients

Effect	Scale Scores		
	Nurturant	Agentic	Self-Governing
Age of Target (AT)	.493	13.048****	2.657
Race of Target (RT)	3.163*	2.358	2.379
Percent of Female Clients (%)	1.288	.178	.633
RT x %	1.605	.077	.286
AT x %	.490	.413	.170
AT x RT	.667	.127	.151
% x RT x AT	.889	1.029	.516

* p<.10 ** p<.05 *** p<.01 **** p<.001

Table 7

Means on Scale Scores by Age and Race of Target and Respondents' Percentage of Female Clients

		N	Nurturant	Agentic	Self-Governing
Target Age	Young	55	4.91	4.98	4.93
	Middle	56	4.97	4.86	4.94
	Old	62	4.98	4.44	4.70
Target Race	White	101	5.01	4.67	4.79
	Black	72	4.88	4.86	4.95
Percentage of Female Clients	1-49%	31	5.02	4.82	4.92
	50-60%	89	4.90	4.76	4.88
	61-99%	53	5.01	4.69	4.77

Table 8

Analyses of Variance on the Scale Scores by Sex and Race of Target and Respondents' Percentage of Old Clients

Effect	Scale Scores		
	Nurturant	Agentic	Self-Governing
Sex of Target (ST)	2.771*	2.590	.810
Race of Target (RT)	1.723	.000	1.043
Percentage of Old Clients (%)	.375	2.911*	2.191
ST x RT	2.482	.560	.153
ST x %	1.155	.170	.502
RT x %	.446	.331	.153
% x ST x RT	.370	1.666	1.202

* p<.10 ** p<.05 *** p<.01 **** p<.001

Table 9

Means on Scale Scores by Sex and Race of Target and Respondents' Percentage of Old Clients

		N	Nurturant	Agentic	Self-Governing
Target Sex	Male	49	4.83	4.66	4.83
	Female	62	4.98	4.44	4.70
Target Race	White	68	4.87	4.53	4.71
	Black	43	4.98	4.54	4.83
Percentage of Old Clients	0%	65	4.88	4.42	4.66
	1-25%	24	4.94	4.63	4.86
	>26%	22	4.97	4.79	4.94

Table 10

Analyses of Variance on the Scale Scores by Sex and Age of Target and Respondents' Percentage of Black Clients

Effect	Scale Scores		
	Nurturant	Agentic	Self-Governing
Sex of Target (ST)	.366	.006	.372
Age of Target (AT)	1.203	11.956****	.911
Percentage of Black Clients (%)	.575	.044	.475
ST x AT	.110	.103	.414
ST x %	2.291	3.257**	1.863
AT x %	.101	2.190*	2.040*
% x ST x AT	1.155	.376	.468

* p<.10 ** p<.05 *** p<.01 **** p<.001

Table 11

Means on Scale Scores by Sex and Age of Target and Respondents' Percentage of Black Clients

		N	Nurturant	Agentic	Self-Governing
Target Sex	Male	85	4.82	4.85	4.89
	Female	75	4.88	4.86	4.94
Target Age	Young	50	4.78	5.07	4.97
	Middle	62	4.82	4.93	4.94
	Old	48	4.96	4.53	4.82
Percentage of Black Clients	0%	45	4.82	4.81	4.84
	1-10%	83	4.83	4.88	4.95
	>10%	32	4.95	4.84	4.93

Table 12

Means for Respondents' Percentage of Black Clients by Sex of Target on Scale Scores

	Nurturant			Agentic			Self-Governing		
	% Black			% Black			% Black		
	1	2	3	1	2	3	1	2	3
Male	4.70	4.79	5.13	4.74	4.85	5.05	4.75	4.91	5.06
Female	4.97	4.87	4.79	4.91	4.92	4.66	4.95	5.00	4.82

Table 13

T-tests on Agentic Scale Score by Percentage of Black Clients and Sex of Target Groups

% Black	Sex	Mean	S.D.	T-value
0%	Male	4.7389	.697	-.91
	Female	4.9053	.533	
1-10%	Male	4.8470	.685	-.52
	Female	4.9197	.583	
>10%	Male	5.0526	.495	0.36*
	Female	4.6594	.516	

* p<.05

Table 14

Analysis of Variance and Means on the Scale Scores by Degree of Similarity between Target and Respondent

		Scale Scores		
	N	Nurturant	Agentic	Self-Governing
0	29	4.95	4.43	4.73
1	103	4.88	4.65	4.79
2	92	4.88	4.82	4.84
3	29	4.85	4.83	4.73
Effect		F	F	F
Similarity		.189	2.461**	.409

* p<.10 ** p<.05 *** p<.01 **** p<.001

CHAPTER 4

DISCUSSION

The present study investigated the relationships between various categories of clinician variables and clinicians' gender stereotypes for men and women varying in age and race. Three scale scores (Nurturant, Agentic, and Self Governing) derived from factor analyses based on the total samples' masculinity and femininity subscale items were utilized as determinants of variations in stereotyping. The similarity between the factor structure of psychological service providers' perceptions of targets (Turner & Turner, 1987) and those derived from self-descriptions of young adult samples (reviewed earlier) suggest convergent validity for the Bem Sex-Role Inventory gender stereotype factors and consequently the derived scale scores as well.

In their study examining psychotherapists' judgments of adult mental health, Turner and Turner (1987) found that white clinicians' beliefs about sex differences on certain masculine traits are strongly influenced by the target's age and race. The above-mentioned research emphasized respondents' perceptions based on target variables varying in age, sex, and race. The significant findings of the Turner and Turner (1987) investigation suggest the importance of also considering the characteristics of the clinicians making the judgments.

Limitations of the Study

There were a number of limitations associated with this investigation that must be considered. The Bem Sex-Role Inventory traits do not represent a comprehensive set of the universe of traits associated with masculinity and femininity. Furthermore, gender differences have been found to be smaller on personality traits (such as those on the BSRI) than on other sex-related characteristics, such as role behaviors, physical traits, and occupations (Kite, et al., 1991) and therefore limits the comparability with previous literature. The favorable depiction (mentally healthy) of the targets, the between-subjects design, and the use of National Register respondents may have reduced stereotypical differences in ratings. Psychotherapists are assumed to be a psychologically sophisticated population which could translate into a gravitation toward social desirability in responses by the clinicians.

In addition, this investigation was unable to address the issue of the race of the therapist. This omission was due to the limited number of minority group clinicians in the total sample. This missing element is significant because minority clinicians will have a number of white clients. As the number of minority group therapists grows, this issue becomes increasingly salient. The assumption should not be made that stereotyped thinking will not be influence this group of clinicians as well as majority group therapists.

An additional limitation was that in several of the analyses, the cell sizes for various target groups were relatively small. A larger sample with a more equitable distribution across cells would strengthen the findings of the study.

Furthermore, the sample was comprised of primarily Ph.D. psychologists. There is a large percentage of psychotherapy that is being performed by social workers, psychiatrists, family counselors, nurses, and trainees in all of these fields. In order to obtain a more comprehensive representation of psychotherapists' person perception judgments, the sample would need to include a wider range of professional disciplines and educational backgrounds.

Socioeconomic status and other variables, such as, expectations, personality patterns, and practice settings, were not included in these analyses. The literature suggests that such variables may have an impact on stereotype formation as well as treatment relationships.

Finally, it is important to note that, in the present study, nurturance, agency, and self-governance were assumed to be positively valued traits. Differences in ratings were assumed to indicate that a particular target group was viewed as possessing more or less of the measured characteristics than other target groups. This manner of measuring stereotypes differs from some of the research (cf. Myers, 1983) which has often focused on negative traits or

attributes of targets. This may limit the generalizability of these findings.

Major Findings

Target Variables

Although the present study emphasized respondent variables, target variables were considered in conjunction with the therapist variables. In all of the analyses, female targets were viewed as more nurturant than male targets. There were no interactions on the feminine-associated measure of nurturant (i.e. communal) traits. Also in all of the analyses, young targets were viewed as significantly more agentic than old and middle-aged targets. Old targets were rated as least agentic. On the self-governing scale score, middle-aged targets were rated as most self-governing. Males were also rated as significantly more agentic than females. The findings provide support for the formulation that people's perceptions of the personal characteristics of males and females are influenced by the social roles they seem to hold. For instance, in earlier social roles research, Eagly and Wood (1982) established that males are perceived as more powerful and influential than females, in part, because males are seen as holding higher status positions.

The findings for old targets are consistent with the social model of stereotype derivation (Eagly & Steffen, 1984) as well. This model suggests that individuals who are believed to be employees are viewed as more agentic than

individuals believed to be retirees or homemakers. The traits included on the Self Governing scale overlap with those on the Agentic scale score. This may account for the age effect on both scales. Interestingly, no main effect for sex of target appeared on the self governing scale. Self governing is related to autonomy and freedom from manipulation. It appears that women are not seen as particularly different from men on this scale. It may be that in this realm, women are less susceptible to being stereotyped. However, on the Agentic score the differential positions that men and women hold in the work force may be influencing the ratings.

Therapist Variables

As noted earlier, therapist race was not considered in this investigation. Although it was not considered in the present study, it is an important variable to be included in future research.

Initial analyses focused on the age of the therapist, divided into three equal-sized age groups. When age of therapist was related to the dependent measures, no main effect or interaction effects with any of the target variables appeared. Therefore, subsequent analyses focused on years of clinical experience as a variable.

Sex of therapist was also related to the dependent variables and no main effect for sex of therapist or interaction effects with any of the target variables appeared. A separate variable, degree of similarity between

target and respondent, was created which incorporated the age and sex of the clinician.

Hypothesis 1 - Theoretical Orientation

Theoretical orientation was significantly related to ratings of agency. Specifically, clinicians categorized as behavioral-rational saw targets as least agentic while clinicians categorized as dynamic and eclectic viewed targets as most agentic. There were no significant interaction effect between theoretical orientation and the target variables. On the scale scores, Nurturant and Self Governing, theoretical orientation did not yield any significant main or interaction effects. There is partial support for the hypothesis that theoretical orientation is not significantly related to gender stereotypes.

One may ask why dynamic and eclectic therapists rate targets across the board as more agentic than other therapists do. It is possible that agency is very important to dynamic therapists. They may see agency as a central component of psychological health.

Also, traditionally, psychodynamically oriented treatments have tended to be a more intensive, longer, and expensive form of psychotherapy. Given the nature of this therapeutic framework, it could be likely that clinicians who use this theoretical orientation would tend to attract persons from middle-class or upper-class socioeconomic backgrounds. As noted earlier, ratings of agency may be tapping into the social roles arena. It could be that

persons from higher socioeconomic groups may be perceived as more powerful and influential as a result of holding higher status positions. If one assumes that dynamic clinicians draw clients from higher social class groups and that socioeconomic status relates to the social role model of stereotype derivation, then this could account for the increased ratings of agency.

In addition, critiques of psychodynamic theory (primarily Freudian theory) have suggested that many of the tenets of this theory are sexist (e.g., Williams, 1985). Specifically, the theory suggest a more favorable evaluation of masculine characteristics and less favorable evaluation of feminine characteristics. Again, if one assumes that this theory values masculine characteristics as compared to feminine characteristics, then this could result in the increased ratings of agency among dynamically oriented clinicians on ratings of psychologically healthy adults.

By definition, eclectic clinicians choose from various therapeutic styles. Due to the use of a range of orientations, it is more difficult to interpret this groups' higher ratings of agency. It could be that this group of clinicians also views agency as a central component of psychological health.

Overall, this finding was quite interesting. The literature, to date, provides few clues by which to interpret this result, and this lack of evidence points to

the need for further investigation into the relationship between theoretical orientation and clinicians' stereotypes.

Hypothesis 2 - Years in Clinical Practice

The hypothesis that experience of clinician would have a significant relationship with gender stereotypes was not supported by these data. It was hypothesized that targets would be rated as possessing positively valued traits by clinicians with more clinical experience. It could be argued that stereotyped responses are less likely among a more experienced group of clinicians. To fully address this question, it would be necessary to include far less experienced clinicians, e.g., therapists in training.

As noted earlier, age of therapist is likely to relate to experience. When age of therapist was related to the dependent variables, no main effects with any of the target variables appeared. In a study representing a wide range of ages among both targets and respondents, it would be possible to test the relationship between experience and stereotyping while controlling for age. Experienced therapists as a group may represent a more narrowly defined range of competencies than less experienced therapists. The issues listed above could have influenced the findings of this study and illustrate the need for further investigation in this area.

Hypothesis 3 - Percentage Client Population

The hypothesis that contact with various categories of clients would result in more positive ratings of those

target groups was partially supported by the findings. First, there was a tendency toward significance on the percent old clients category on the Agentic scale score. Specifically, clinicians with the greatest amount of contact with old clients rated old targets as most agentic while those with the least amount of contact rated old targets as least agentic.

The strong relationship that exists between the rating of agency and age of targets could be creating a greater pull for stereotyped responses on the percent old clients category. Those with the most contact with old clients perceived old targets as possessing significantly greater agency than those with no old clients in their clinical practices. This may also be related to the social role stereotype model. Specifically, clinicians may view therapy as "working"; it entails taking action, making changes. In treatment, one may discuss his or her aspirations and goals. Given that several salient features of agency are activity, power, and instrumentality, clinicians with more contact with old clients may tend to rate older adults as more agentic because of their contact with clients who have entered into treatment. Also, it is generally thought that older people give up traditional social roles and therefore, clinicians with no contact with old clients may buy into this notion and perceive decreased agency in old targets.

It was also found that for the variable, percentage of black clients, as the percentage of black clients in a

clinicians' practice increased, the ratings of agency of black male targets also increased. An inverse relationship appeared on ratings of agency for black female targets; the greater the percentage of black clients, the more likely was the therapist to rate the black female targets as less agentic. Specifically, black males and black females were rated as significantly different by clinicians with the largest percentage of black clients in their practices.

The question becomes how to understand this relationship. It has been established that men are less likely to enter into therapy than women (Whitley, 1979). This difference applies for black and white persons. It could be that those black males who do enter treatment may be more likely to come from higher socioeconomic status backgrounds and hold white-collar occupational positions. It could be argued that clinicians with the most contact with black clients would tend to rate black male targets as possessing increased agency due to their contact with black males in higher status positions. Those with no contact may be using stereotypes to determine their perceptions of black males. It is possible that the decreased ratings reflect perceptions of black males as less agentic due to the frequent examples given by a variety of sources that portray black men as unemployed.

Given that women enter treatment at a higher rate than males, it could be reasoned that a wider range of socioeconomic groups are represented among women in

therapists' practices. Higher ratings of agency may be found for those clinicians with no contact with black clients because this group may be seeing black women as more likely to fit the stereotypical image of the "matriarch" (or the single mother, head of the household). It could be argued that those with greater contact with black clients may perceive black women as possessing less agency due to a likelihood that they may see black women as having a broader spectrum of social roles.

The above speculations illustrate the importance of research that includes more data on client and therapist variables.

Hypothesis 4 - Similarity between Respondent and Target

Finally, on this hypothesis, it was found that on the masculine-associated characteristic of agency, the degree of similarity with target had a significant relationship with clinicians' gender stereotypes. Specifically, clinicians with a greater degree of similarity with targets saw those targets as most agentic. The Nurturant and Self-Governing scale scores did not yield any significant results. One interpretation is that therapists see agency as especially important and identify with targets most similar in sex, age, and race with themselves and then rate them high on agency. This finding is consistent with the ingroup-outgroup literature, which states that there is a tendency to view positively those most like ourselves (Myers, 1983).

The question becomes which are the variables (age, sex, or race) that account for this significant finding. One way analyses of variance performed on the individual race, sex, and age similarity variables (similarity in sex, similarity in age, and similarity in race), indicated that age contributed the most to this finding. It is interesting to note that as a separate variable, age of respondent yielded no significant findings. As a separate variable, age of target was found to significantly relate to ratings of agency. It could be that clinicians gave ratings of highest agency to those targets of similar age due to this variable's perceived importance as a determinant of psychological health.

Implications and conclusions

These findings suggest many areas for further investigation. Future studies might use likelihood estimations of the social roles of targets varying in age-cohort, sex, and race. More specifically, likelihood estimations of employment versus retirement or homemaking and of holding high or low status jobs would be useful. Also biological and appearance characteristics might be considered and this might best be done by conducting open-ended interviews rather than utilizing surveys.

Along those lines, increased data on clinicians would be important. It would be important to consider socioeconomic status as a demographic variable and clinical practice settings (e.g., hospitals, clinicians, private

practice, etc.). In addition, as noted in Beutler, Crago, and Arizmendi (1986) internal, inferred characteristics (e.g., expectations, emotional well-being) also need to be addressed.

The findings suggest that the variable, Agency, is particularly associated with ratings of psychological health. This variable seems to pull for differential ratings of targets by clinicians. This finding points to the need for additional research that investigates the role "agency" plays in stereotypical thinking and how it is that clinicians define psychological health.

The findings on the scale scores could be understood by the changing of social roles over time. Females as well as older people have entered the work force in increasing numbers over time. Also, more males are taking on child care responsibilities. Perhaps the pull on the agentic scale for stereotyped responses is related to the fact that the groups that have entered the work force tend to hold lower status positions.

With regard to clinical practice, several implications arise. The Turner and Turner study (1987) did find stereotypes in operation among psychologists. Individuals tend to use stereotypes when there is little or very general information available about an individual. At the outset of treatment, it is generally assumed that the clinician has minimal information available about the client. It could be that at this early point in the treatment, clinicians would

be more vulnerable to relying on stereotypes to help them understand certain client dynamics or behaviors. Moreover, the current study has found that evaluation of targets varies by the therapist characteristics of degree of similarity with client, theoretical orientation, and percentage of old clients and percentage of black clients on the masculine-associated measure termed Agency. It could be argued that these variations in evaluations may be translated into differential behavior that has the potential to affect treatment relationships. Specifically, this differential behavior could have the effect of increasing the likelihood of premature terminations, biased diagnoses, inappropriate referrals, etc.

It is also important to note that treatment implies an interaction; a relationship. Research needs to be done on client stereotypes and the nature of their interaction with therapist stereotypes. It would also be important to investigate how directly stereotypes of clients and therapists may or may not translate into discriminatory behavior.

The multitude of findings of the stereotype literature also seem to suggest changing perceptions of gender over time. This may have implications for the theory of stereotype formation. Individuals may have used different schemata for categorizing groups than in earlier times. This suggests a need for methods of determining stereotypes which are sensitive to changes over time.

The above are all methodologically difficult lines of research because many of the variables are difficult to systematically control. However, the findings of this study illustrate the importance of gaining additional understanding of the complex interactions between therapist and client characteristics.

The present study addressed gender stereotypes and defined those as structured sets of beliefs or generalizations about the characteristics of men and women (cf. Ashmore & Del Boca, 1986). However, it seems that an area for further theoretical development might address the issues of individual differences and overgeneralization, i.e., how does one determine that a stereotype is positive or negative in meaning and when is it appropriate to overgeneralize and when is it appropriate to pay attention to individual differences. Traditionally there seems to have been an implicit assumption that stereotypical thinking is "negative". This assumption is one that could impact on treatment as well as clinical training and development. However one could argue that there is benefit to be gained from general category information. Additional thinking and research on the premises underlying stereotype development is needed.

APPENDIX: PSYCHOTHERPISTS' PERCEPTIONS OF ADULT PSYCHOLOGICAL HEALTH

PSYCHOTHERAPISTS' PERCEPTIONS OF ADULT PSYCHOLOGICAL HEALTH

Barbara L. Turner, Ph.D.
Cass Turner, Ph.D.

Principal Investigators
1986

On the following page, you will be shown a number of personality characteristics. We would like you to use those characteristics in order to describe a normal ADULT BLACK WOMAN in her LATE 60's. That is, we would like you to indicate, on a scale from 1 to 7, how true these various characteristics are of a mature, healthy, socially competent ADULT BLACK WOMAN in her LATE 60's. Please do not leave any characteristics unmarked.

Example: generous

Mark a 1 if it is NEVER OR ALMOST NEVER TRUE that she is generous.

Mark a 2 if it is USUALLY NOT TRUE that she is generous.

Mark a 3 if it is SOMETIMES BUT INFREQUENTLY TRUE that she is generous.

Mark a 4 if it is OCCASIONALLY TRUE that she is generous.

Mark a 5 if it is OFTEN TRUE that she is generous.

Mark a 6 if it is USUALLY TRUE that she is generous.

Mark a 7 if it is ALWAYS OR ALMOST ALWAYS TRUE that she is generous.

Thus, if you feel it is often true that a mature, healthy, socially competent ADULT BLACK WOMAN in her LATE 60's is "generous", never or almost never true that she is "malicious", and always or almost always true that she is "responsible", then you would rate these characteristics as follows:

Generous	5
Malicious	1
Responsible	7

1	2	3	4	5	6	7
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE	OFTEN TRUE	USUALLY TRUE	ALMOST OR ALMOST ALWAYS TRUE

1.	Self-reliant		21.	Reliable		41.	Warm	
2.	Yielding		22.	Analytical		42.	Solemn	
3.	Helpful		23.	Sympathetic		43.	Willing to take a stand	
4.	Defends own beliefs		24.	Jealous		44.	Tender	
5.	Cheerful		25.	Has leadership abilities		45.	Friendly	
6.	Moody		26.	Sensitive to the needs of others		46.	Aggressive	
7.	Independent		27.	Truthful		47.	Gullible	
8.	Shy		28.	Willing to take risks		48.	Inefficient	
9.	Conscientious		29.	Understanding		49.	Acts as a leader	
10.	Athletic		30.	Secretive		50.	Childlike	
11.	Affectionate		31.	Makes decisions easily		51.	Adaptable	
12.	Theatrical		32.	Compassionate		52.	Individualistic	
13.	Assertive		33.	Sincere		53.	Does not use harsh language	
14.	Flatterable		34.	Self-sufficient		54.	Unsystematic	
15.	Happy		35.	Eager to soothe hurt feelings		55.	Competitive	
16.	Strong personality		36.	Conceited		56.	Loves children	
17.	Loyal		37.	Dominant		57.	Tactful	
18.	Unpredictable		38.	Soft-spoken		58.	Ambitious	
19.	Forceful		39.	Likeable		59.	Gentle	
20.	Feminine		40.	Masculine		60.	Conventional	

DIRECTIONS

We would like to know something about people's expectations of others. Each item of this questionnaire will ask you to respond with a slash (/) along a continuum. Think of a normal ADULT BLACK WOMAN in her LATE 60's and indicate on each item what you think a mature, healthy, socially competent ADULT BLACK WOMAN in her LATE 60's would be like.

For example, what would you expect about this person's likes or dislikes regarding the color red? Below is an illustration of how to fill out the questionnaire.

EXAMPLE:

STRONG DISLIKE FOR COLOR RED 1.....2.....3.....4.....5..../....6.....7 STRONG LIKE FOR COLOR RED

QUESTIONNAIRE ITEMS

61. NOT AT ALL AGGRESSIVE 1.....2.....3.....4.....5.....6.....7 VERY AGGRESSIVE

62. VERY IRRATIONAL 1.....2.....3.....4.....5.....6.....7 VERY RATIONAL

63. VERY PRACTICAL 1.....2.....3.....4.....5.....6.....7 VERY IMPRACTICAL

64. NOT AT ALL INDEPENDENT 1.....2.....3.....4.....5.....6.....7 VERY INDEPENDENT

65. NOT AT ALL CONSISTENT 1.....2.....3.....4.....5.....6.....7 VERY CONSISTENT

66. VERY EMOTIONAL 1.....2.....3.....4.....5.....6.....7 NOT AT ALL EMOTIONAL

67. VERY REALISTIC 1.....2.....3.....4.....5.....6.....7 NOT AT ALL REALISTIC

68. NOT AT ALL IDEALISTIC 1.....2.....3.....4.....5.....6.....7 VERY IDEALISTIC

69. DOES NOT HIDE EMOTIONS 1.....2.....3.....4.....5.....6.....7 ALMOST ALWAYS HIDES EMOTIONS

70. VERY SUBJECTIVE 1.....2.....3.....4.....5.....6.....7 VERY OBJECTIVE

71. MAINLY INTERESTED IN DETAIL 1.....2.....3.....4.....5.....6.....7 MAINLY INTERESTED IN GENERALITIES

72. ALWAYS THINKS BEFORE ACTS 1.....2.....3.....4.....5.....6.....7 NEVER THINKS BEFORE ACTS

73. NOT AT ALL EASILY INFLUENCED 1.....2.....3.....4.....5.....6.....7 VERY EASILY INFLUENCED

74. NOT AT ALL TALKATIVE 1.....2.....3.....4.....5.....6.....7 VERY TALKATIVE

75. VERY GRATEFUL 1.....2.....3.....4.....5.....6.....7 VERY UNGRATEFUL

76. DOESN'T MIND AT ALL WHEN THINGS ARE UNCLEAR 1.....2.....3.....4.....5.....6.....7 MINDS VERY MUCH WHEN THINGS ARE UNCLEAR

77. VERY DOMINANT 1.....2.....3.....4.....5.....6.....7 VERY SUBMISSIVE

78. DISLIKES MATH & SCIENCE 1.....2.....3.....4.....5.....6.....7 LIKES MATH & SCIENCE VERY WELL

79. NOT AT ALL RECKLESS 1.....2.....3.....4.....5.....6.....7 VERY RECKLESS

80. NOT AT ALL EXCITABLE IN A MAJOR CRISIS 1.....2.....3.....4.....5.....6.....7 VERY EXCITABLE IN A MAJOR CRISIS

81. NOT AT ALL EXCITABLE IN A MINOR CRISIS 1.....2.....3.....4.....5.....6.....7 VERY EXCITABLE IN A MINOR CRISIS

82. NOT AT ALL STRICT 1.....2.....3.....4.....5.....6.....7 VERY STRICT

83. VERY WEAK PERSONALITY 1.....2.....3.....4.....5.....6.....7 VERY STRONG PERSONALITY

84. VERY ACTIVE 1.....2.....3.....4.....5.....6.....7 VERY PASSIVE

85. NOT AT ALL ABLE TO DEVOTE SELF TO OTHERS 1.....2.....3.....4.....5.....6.....7 ABLE TO DEVOTE SELF COMPLETELY TO OTHERS

86. VERY BLUNT 1.....2.....3.....4.....5.....6.....7 VERY TACTFUL

87. VERY GENTLE 1.....2.....3.....4.....5.....6.....7 VERY ROUGH

88. VERY HELPFUL TO OTHERS 1.....2.....3.....4.....5.....6.....7 NOT AT ALL HELPFUL TO OTHERS

89. NOT AT ALL COMPETITIVE 1.....2.....3.....4.....5.....6.....7 VERY COMPETITIVE

90. VERY LOGICAL 1.....2.....3.....4.....5.....6.....7 VERY ILLOGICAL

91. NOT AT ALL COMPETENT 1.....2.....3.....4.....5.....6.....7 VERY COMPETENT

92. VERY WORLDLY 1.....2.....3.....4.....5.....6.....7 VERY HOME ORIENTED

93. NOT AT ALL SKILLED IN BUSINESS 1.....2.....3.....4.....5.....6.....7 VERY SKILLED IN BUSINESS

94. VERY DIRECT 1.....2.....3.....4.....5.....6.....7 VERY SNEAKY

95. KNOWS THE WAY OF THE WORLD 1.....2.....3.....4.....5.....6.....7 DOES NOT KNOW THE WAY OF THE WORLD

96. NOT AT ALL KIND 1.....2.....3.....4.....5.....6.....7 VERY KIND

97. NOT WILLING TO ACCEPT CHANGE 1.....2.....3.....4.....5.....6.....7 VERY WILLING TO ACCEPT CHANGE

98. FEELINGS NOT EASILY HURT 1.....2.....3.....4.....5.....6.....7 FEELINGS EASILY HURT

99. NOT AT ALL ADVENTUROUS 1.....2.....3.....4.....5.....6.....7 VERY ADVENTUROUS

100. VERY AWARE OF THE FEELINGS OF OTHERS 1.....2.....3.....4.....5.....6.....7 NOT AT ALL AWARE OF THE FEELINGS OF OTHERS

101. NOT AT ALL RELIGIOUS 1.....2.....3.....4.....5.....6.....7 VERY RELIGIOUS

102. NOT AT ALL INTELLIGENT 1.....2.....3.....4.....5.....6.....7 VERY INTELLIGENT

103. NOT AT ALL INTERESTED IN OWN APPEARANCE 1.....2.....3.....4.....5.....6.....7 VERY INTERESTED IN OWN APPEARANCE

104. CAN MAKE DECISIONS EASILY 1.....2.....3.....4.....5.....6.....7 HAS DIFFICULTY MAKING DECISIONS

105. GIVES UP VERY EASILY 1.....2.....3.....4.....5.....6.....7 NEVER GIVES UP EASILY

106. VERY SHY 1.....2.....3.....4.....5.....6.....7 VERY OUTGOING

107. ALWAYS DOES THINGS WITHOUT BEING TOLD 1.....2.....3.....4.....5.....6.....7 NEVER DOES THINGS WITHOUT BEING TOLD

108. NEVER CRIES 1.....2.....3.....4.....5.....6.....7 CRIES VERY EASILY

109. ALMOST NEVER ACTS AS A LEADER 1.....2.....3.....4.....5.....6.....7 ALMOST ALWAYS ACTS AS A LEADER

110. NEVER WORRIED 1.....2.....3.....4.....5.....6.....7 ALWAYS WORRIED

111. VERY NEAT IN HABITS 1.....2.....3.....4.....5.....6.....7 VERY SLOPPY HABITS

112. VERY QUIET 1.....2.....3.....4.....5.....6.....7 VERY LOUD

113. NOT AT ALL INTELLECTUAL 1.....2.....3.....4.....5.....6.....7 VERY INTELLECTUAL

114. VERY CAREFUL 1.....2.....3.....4.....5.....6.....7 VERY CARELESS

115. NOT AT ALL SELF-CONFIDENT 1.....2.....3.....4.....5.....6.....7 VERY SELF-CONFIDENT

116. FEELS VERY SUPERIOR 1.....2.....3.....4.....5.....6.....7 FEELS VERY INFERIOR

117. ALWAYS SEES SELF AS RUNNING SHOW 1.....2.....3.....4.....5.....6.....7 NEVER SEES SELF AS RUNNING THE SHOW

118. NOT AT ALL UNCOMFORTABLE ABOUT BEING AGGRESSIVE 1.....2.....3.....4.....5.....6.....7 VERY UNCOMFORTABLE ABOUT BEING AGGRESSIVE

119. VERY GOOD SENSE OF HUMOR 1.....2.....3.....4.....5.....6.....7 VERY POOR SENSE OF HUMOR

120. NOT AT ALL UNDERSTANDING OF OTHERS 1.....2.....3.....4.....5.....6.....7 VERY UNDERSTANDING OF OTHERS

121. VERY WARM IN RELATIONS WITH OTHERS 1.....2.....3.....4.....5.....6.....7 VERY COLD IN RELATIONS WITH OTHERS

122. DOESN'T CARE FOR BEING IN A GROUP 1.....2.....3.....4.....5.....6.....7 GREATLY PREFERS BEING IN A GROUP

123. VERY LITTLE NEED FOR SECURITY 1.....2.....3.....4.....5.....6.....7 VERY STRONG NEED FOR SECURITY

124. NOT AT ALL AMBITIOUS 1.....2.....3.....4.....5.....6.....7 VERY AMBITIOUS

125. VERY RARELY TAKES EXTREME POSITIONS 1.....2.....3.....4.....5.....6.....7 VERY FREQUENTLY TAKES EXTREME POSITIONS

126. ABLE TO SEPARATE FEELINGS FROM IDEAS 1.....2.....3.....4.....5.....6.....7 UNABLE TO SEPARATE FEELINGS FROM IDEAS

127. NOT AT ALL DEPENDENT 1.....2.....3.....4.....5.....6.....7 VERY DEPENDENT

128. DOES NOT ENJOY ART AND LITERATURE AT ALL 1.....2.....3.....4.....5.....6.....7 ENJOYS ART AND LITERATURE VERY MUCH

129. SEEKS OUT NEW EXPERIENCES 1.....2.....3.....4.....5.....6.....7 AVOIDS NEW EXPERIENCES

130. NOT AT ALL RESTLESS 1.....2.....3.....4.....5.....6.....7 VERY RESTLESS

131. VERY UNCOMFORTABLE WHEN PEOPLE EXPRESS EMOTIONS 1.....2.....3.....4.....5.....6.....7 NOT UNCOMFORTABLE WHEN PEOPLE EXPRESS EMOTIONS

132. EASILY EXPRESSES TENDER EMOTIONS 1.....2.....3.....4.....5.....6.....7 DOES NOT EXPRESS TENDER FEELINGS EASILY

133. VERY CONCEITED ABOUT APPEARANCE 1.....2.....3.....4.....5.....6.....7 NEVER CONCEITED ABOUT APPEARANCE

134. RETIRING 1.....2.....3.....4.....5.....6.....7 FORWARD

135. VERY SOCIABLE 1.....2.....3.....4.....5.....6.....7 NOT AT ALL SOCIABLE

136. VERY AFFECTIONATE 1.....2.....3.....4.....5.....6.....7 NOT AT ALL AFFECTIONATE

137. VERY CONVENTIONAL 1.....2.....3.....4.....5.....6.....7 NOT AT ALL CONVENTIONAL

138. VERY ASSERTIVE 1.....2.....3.....4.....5.....6.....7 NOT AT ALL ASSERTIVE

139. VERY IMPULSIVE 1.....2.....3.....4.....5.....6.....7 NOT AT ALL IMPULSIVE

CONTINUE TO NEXT PAGE

PERSONAL DATA QUESTIONS

140. What is your sex? (Circle numer of your answer)

1. MALE
2. FEMALE

141. What is your age? _____ years

142. What is your race? (Circle number)

1. White
2. Black
3. Asian/Pacific Islander
4. Hispanic
5. Other (Please specify _____)

143. In what year did you earn your highest degree? _____

144. Are you in active clinical practice? (Circle number)

1. YES
2. NO

145. What ONE orientation would you MOST identify with? (Circle number)

1. Behavioral
2. Client-centered
3. Eclectic
4. Interpersonal
5. Psychoanalytic
6. Rational Emotive/Cognitive
7. Systems Theory
8. Other (Plese specify _____)

For questions 146, 157, and 148, what percentage of your clients are:

146. _____% MALE

_____% FEMALE

147. What percentage of your clients are: _____% White

_____% Black

_____% Other (Please specify _____)

148. Please check ONE for EACH age group:

	NONE	UP TO 25%	26-50%	51-75%	75% AND OVER
UNDER AGE 18 YR					
AGE 18-24					
AGE 25-29					
AGE 30-44					
AGE 45-49					
AGE 50-64					
AGE 65-69					
AGE 70+ YR					

Your contribution to this study is very greatly appreciated.

REFERENCES

Acosta, F., Yamamoto, J., & Evans, L. (1982). Effective psychotherapy for low-income and minority patients. New York: Plenum Press.

Adams, P. (1970). Dealing with racism in biracial psychiatry. Journal of American Academy of Child Psychiatry, 9, 33-43.

Allen, V. L., & Wilder, D. A. (1979). Group categorization and attribution of belief similarity. Small Group Behavior, 10, 73-80.

Ashmore, R., Del Boca, F., & Wohlers, A. (1986). Gender stereotypes. In R. D. Ashmore & F. R. Del Boca (Eds.), The social psychology of female-male relations (pp. 69-120). Orlando, FL: Academic Press.

Auerbach, D., & Johnson, M. (1977). Research on therapist's level of experience. In A. S. Gurman & A. M. Razin (Eds.), Effective psychotherapies: A handbook of research (pp. 84-102). New York: Pergamon.

Bakan, D. (1966). The duality of human existence: An essay on psychology and religion. Chicago: Rand McNally.

Barrett, C. L., & Wright, J. H. (1984). Therapist variables. In M. Hersen, L. Michelson, & A. S. Bellack (Eds.), Issues in psychotherapy research (pp. 361-391). New York: Plenum.

Bem, S. L. (1974). The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology, 42, 155-162.

Bennett, R., & Eckman, J. (1973). Attitudes toward aging: A critical examination of recent literature and implications for future research. In C. Eisdorfer & M. Lawton (Eds.), Psychology of adult development and aging (pp. 2257-309). Washington, D.C.: American Psychological Association.

Bernstein, B. L., & Figioli, S. W. (1983). Gender and credibility introduction effects on perceived counselor characteristics. Journal of Consulting Psychology, 30, 506-513.

Bernstein, B., & Lecomte, C. (1982). Therapist expectancies: Client gender and therapist gender, profession and level of training. Journal of Clinical Psychology, 38, 744-754.

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Therapist variables in psychotherapy process and outcome. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis (3rd ed. pp. 257-309). New York: Wiley.

Blackburn, I. M., Bishop, S., Glen, A. I. M., Whalley, L. G., & Christie, J. E. (1981). The efficacy of cognitive therapy in depression: A treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. British Journal of Psychiatry, 139, 181-189.

Blase, J. J. (1979). A study of the effects of sex of the client and sex of the therapist on clients' satisfaction with psychotherapy. Dissertation Abstracts International, 30, 6107B-6108B.

Bloom, L. J., Weigel, R. G., & Trautt, G. M. (1977). "Therapeugenic" factors in psychotherapy: Effects of office decor and subject-therapist pairing on the perception of credibility. Journal of Consulting and Clinical Psychology, 45, 867-873.

Brenner, D. (1982). The effective psychotherapist, conclusions from practice and research. New York: Pergamon Press.

Brigham, J. C. (1971). Ethnic stereotypes. Psychological Bulletin, 76, 15-38.

Brigham, J. C., & Williamson, N. L. (1979). Cross-racial recognition and age: When you're over 60, do they still all look alike? Personality and Social Psychology Bulletin, 7, 475-480.

Broverman, I., Broverman, D., Clarkson, F., Rosenkrantz, P., & Vogel, S. (1970). Sex-role stereotypes and clinical judgments of mental health. Journal of Consulting and Clinical Psychology, 34, 1-7.

Brown, C. R., & Hellinger, M. L. (1975). Therapists' attitudes toward women. Social Work, 20, 266-270.

Cartwright, R. D., & Lerner, B. (1963). Empathy, need to change, and improvement with psychotherapy. Journal of Consulting Psychology, 27, 138-144.

Cavenar, J. O. Jr., & Werman, D. S. (1983). The sex of the psychotherapist. American Journal of Psychiatry, 140, 85-87.

Chance, J. (1959). Families in treatment. New York: Basic Books.

Chance, J. E., & Goldstein, A. B. (1981). Depth of processing in response to own- and other-race faces. Personality and Social Psychology Bulletin, 7, 475-480.

Ciano-Boyce, C., Turner, B. F., & Turner, C. B. (1988). Sex stereotypes and clinical judgments of mental health among marital and family therapists. Journal of Independent Social Work, 3, 57-70.

Crocker, J., Hannah, D. B., & Weber, R. (1983). Personal memory and causal attributions. Journal of Personality and Social Psychology, 44, 55-66.

Crockett, W. H., & Hummert, M. L. (1987). Perceptions of aging and the elderly. In C. Eisdorfer (Ed.), Annual review of gerontology and geriatrics. New York: Springer.

Cross, D. G., & Sheehan, P. W. (1982). Secondary therapist variables operating in short-term insight-oriented and behavior therapy. British Journal of Medical Psychology, 55, 275-284.

Davenport, J., & Reims, N. (1978). Theoretical orientation and attitude toward women. Social Work, 23, 306-309.

Dembo, R., Ikle, D. N., & Ciarlo, J. A. (1983). The influence of client-clinician demographic match on client treatment outcomes. Journal of Psychiatric Treatment and Evaluation, 5, 45-53.

Deutsch, F. M., Zalenski, C. M., & Clark, M. E. (1986). Is there a double standard of aging? Journal of Applied Social Psychology, 16, 771-785.

Deaux, K. (1984). From individual differences to social categories: Analysis of a decade's research on gender. American Psychologist, 39, 105-116.

Deaux, K., & Lewis, L. L. (1983). Components of gender stereotypes. Psychological Documents, 13, 25 (Ms. No. 2583).

Deaux, K., & Kite, M. (1987). Thinking about gender. In B. B. Hess & M. M. Ferree (Eds.), Analyzing gender: A handbook of social science research (pp. 92-117). Beverly Hills, CA: Sage.

Deaux, K., & Lewis, L. L. (1984). Structure of gender stereotypes: Interrelationships among components and gender label. Journal of Personality and Social Psychology, 46, 991-1004.

Donnan, H. H., & Mitchell, H. D. Jr. (1979). Preferences for older versus younger counselors among a group of elderly persons. Journal of Counseling Psychology, 26, 514-518.

Drevenstedt, J. (1976). Perceptions of onsets of young adulthood, middle age, and old age. Journal of Gerontology, 31, 53-57.

Eagly, A. H., & Steffen, V. J. (1984). Gender stereotypes stem from the distribution of women and men into social roles. Journal of Personality and Social Psychology, 46, 735-754.

Eagly, A. H., & Wood, W. (1982). Inferred sex differences in status as a determinant of gender stereotypes about social influence. Journal of Personality and Social Psychology, 43, 915-928.

Fiedler, F. F. (1950). The concept of an ideal therapeutic relationship. Journal of Consulting Psychology, 14, 239-245.

Fisher, E. H., & Howard, K. I. (1984, June). The process of outcome in psychotherapy as a function of gender pairing. Paper presented at the meeting of the Society for Psychotherapy Research, Lake Louise Ontario, Canada.

Ford, C., & Sbordonne, R. (1980). Attitudes of psychiatrists toward elderly patients. American Journal of Psychiatry, 137, 571-575.

Friedman, M. (1966). James Baldwin and psychotherapy. Psychotherapy: Theory, Research and Practice, 3, 177-183.

Fry, P., Kopf, G., & Coe, K. (1980). Effects of counselor and client racial similarity on counselor's response pattern and skills. Journal of Counseling Psychology, 27, 130-137.

Futoran, G. C., & Wyer, R. S. Jr. (1986). The effects of traits and gender stereotypes on occupational suitability judgments and the recall of judgment relevant information. Journal of Experimental Social Psychology, 45, 475-503.

Garfinkel, R. (1975). The reluctant therapist. Gerontologist, 15, 136-137.

Gatz, M., & Pearson, C. (1988). Ageism revised and the provision of psychological services. American Psychologist, 43, 184-188.

Gaudreau, P. (1977). Factor analysis of the Bem Sex-Role Inventory. Journal of Consulting and Clinical Psychology, 45, 299-302.

Getz, H. G., & Miles, J. H. (1978). Women and peers as counselors: A look at client preferences. Journal of College Student Personnel, 19, 37-41.

Grantham, R. (1973). Effects of counselor sex, race and language style on black students in initial interviews. Journal of Counseling Psychology, 20, 553-559.

Haccoun, D. M., & Lavigueur, H. (1979). Effects of clinical experience and client emotion on therapists' responses. Journal of Consulting and Clinical Psychology, 47, 416-418.

Hamilton, D. L., & Rose, T. L. (1980). Illusory correlation and the maintenance of stereotypic beliefs. Journal of Personality and Social Psychology, 39, 832-845.

Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A black and white model. Counseling Psychologist, 12, 153-165.

Helwig, A. A. (1976). Counselor bias and women. Journal of Employment Counseling, 13, 58-67.

Houts, A. C. (1984). Effects of clinician theoretical orientation and patient explanatory bias on initial clinical judgments. Professional Psychology Research and Practice, 15, 284-293.

Ickes, W., Patterson, M. L., Rajecki, D. W., & Tanford, S. (1982). Behavioral and cognitive consequences of reciprocal versus compensatory response to pre-interaction expectancies. Social Cognition, 1, 160-190.

Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. Psychotherapy: Theory, Research and Practice, 10, 270-272.

Jones, E. E. (1982). Psychotherapists' impressions of treatment outcome as a function of race. Journal of Clinical Psychology, 38, 722-731.

Jones, E. E., & Zoppel, C. L. (1982). Impact of client and therapist gender on psychotherapy process and outcome. Journal of Consulting and Clinical Psychology, 50, 259-272.

Jones, M. H., & Jones, M. C. (1970). The neglected client. The Black Scholar, 5, 35-42.

Kaplan, A. G. (1985). Female or male therapists for women patients: New formulations. Psychiatry, 48, 111-121.

Karasu, T., Stein, S. P., & Charles, E. (1979). Age factors in the patient-therapist relationship. Journal of Nervous and Mental Disease, 167, 100-104.

Kaschak, E. (1978). Therapist and client: Two views of the process and outcome of psychotherapy. Professional Psychology, 9, 271-277.

Kirshner, L. A., Genack, A., & Hauser, S. T. (1978). Effects of gender on short-term psychotherapy. Psychotherapy: Theory, Research and Practice, 15, 158-167.

Kite, M. E., Deaux, K., & Miele, M. (1991). Stereotypes of young and old: Does age outweigh gender? Psychology and Aging, 6, 19-27.

Kite, M. E., & Johnson, B. T. (1988). Attitudes toward older and younger adults: A meta-analysis. Psychology and Aging, 3, 233-244.

Knight, B. (1985-86). Therapists' attitudes as explanation of underservice of the elderly in mental health: Testing an old hypothesis. International Journal of Aging and Human Development, 22, 261-269.

Lasky, R. G., & Salomone, P.R. (1977). Attraction to psychotherapy: Influences of therapist status and therapist-patient age similarity. Journal of Clinical Psychology, 33, 511-516.

Lee, D. Y., Hallberg, E. G., Jones, L., & Haase, R. F. (1980). Effects of counselor gender on perceived credibility. Journal of Counseling Psychology, 27, 71-75.

Lewis, J. M., & Johansen, K. H. (1982). Resistances to psychotherapy with the elderly. American Journal of Psychotherapy, 36, 497-504.

Locksley, A., Hepburn, C., & Ortiz, V. (1982). Social stereotypes and judgments of individuals: An instance of the base-rate fallacy. Journal of Experimental Social Psychology, 18, 23-42.

Lopez, S., & Hernandez, P. (1986). How culture is considered in evaluations of psychopathology. Annual Meeting of the Western Psychological Association (1984, Los Angeles, CA). Journal of Nervous and Mental Disease, 174, 598-606.

Luborsky, L., Crits-Cristoph, P., Alexander, L., Margolis, M., & Cohen, M. (1983a). Two helping alliance methods for predicting outcomes of psychotherapy. A counting signs vs. global rating method. Journal of Nervous and Mental Disease, 171, 480-491.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes"? Archives of General Psychiatry, 32, 995-1008.

Luszcz, M. A. (1985-86). Characterizing adolescents, middle-aged and elderly adults: Putting the elderly into perspective. International Journal of Aging and Human Development, 22, 105-121.

Lutsky, N. (1980). Attitudes toward old age and elderly persons. Annual Review of Gerontology and Geriatrics, 1, 287-335.

Martin, R. M., & Prosen, H. (1976). Psychotherapy supervision and life tasks. The young therapist and the middle-aged patient. Bulletin of the Menninger Clinic, 40, 125-133.

McArthur, L.Z., & Friedman, S.A. (1980). Illusory correlation in impression formation: Variations in the shared distinctiveness effect as a function of the distinctive person's age, race, and sex. Journal of Personality and Social Psychology, 39, 615-624.

Messick, D. M., & Mackie, D. M. (1989). Intergroup relations. In M. R. Rosenzweig & L. W. Porter (Eds.), Annual review of psychology (Vol. 40 pp. 45-82). Palo Alto, CA: Annual Reviews, Inc.

Miele, M. A., & Deaux, K. (1989, August). Stereotypes of the elderly: Age and gender variations. Paper presented at the 97th Annual Convention of the American Psychological Association, New Orleans, LA.

Miller, R. C., & Berman, J. S. (1983). The efficacy of cognitive behavior therapies: A quantitative review of the research evidence. Psychological Bulletin, 94, 39-53.

Minrath, M. (1985). Breaking the race barrier. Journal of Psychosocial Nursing Mental Health Service, 23, 19-20.

Mogul, K. M. (1982). Overview: The sex of the therapist. American Journal of Psychiatry, 139, 1-11.

Morgan, R., Luborsky, L., Crits-Cristoph, P., Curtis, H., & Solomon, J. (1982). Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. Archives of General Psychiatry, 39, 397-402.

Myers, D. G. (1983). Social Psychology. New York: McGraw-Hill Book Co.

Orlinsky, D. E., & Howard, K. I. (1976). The effects of sex of therapist on the therapeutic experiences of women. Psychotherapy: Theory, Research and Practice, 13, 82-88.

Parloff, M. B., Waskow, I. E., & Wolfe, B. E. (1978). Research of therapist variables in relation to process and outcome. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change. (2nd ed., pp.233-282). New York: Wiley.

Pedhazur, E. J., & Tetenbaum T. J. (1979). Bem Sex-Role Inventory: A theoretical and methodological critique. Journal of Personality and Social Psychology, 37, 996-1016.

Pettigrew, T. F. (1980). Prejudice. In S. Thernstrom, et al. (Eds.), Harvard encyclopedia of american ethnic groups. Cambridge, MA: Harvard University Press.

Phillips, R. D. (1985). The adjustment of men and women: Mental health professionals' views today. [Special Issue: Gender Roles]. Academic Psychology Bulletin, 7, 253-260.

Proctor, E. K., & Rosen, A. (1981). Expectations and preferences for counselor race and their relation to intermediate treatment outcomes. Journal of Counseling Psychology, 28, 40-46.

Quattrone, G. A., & Jones, E. E. (1980). The perception of variability within in-groups and out-groups: Implications for the law of small numbers. Journal of Personality and Social Psychology, 39, 832-845.

Ray, D. C., McKinney, K. A., & Ford, C. V. (1987). Differences in psychologists' ratings of older and younger clients. Gerontologist, 27, 82-86.

Rokeach, M., & Mezei, L. (1966). Race and shared beliefs as factors in social choice. Science, 151, 167-172.

Rosencrantz, P. A., Vogel, S. R., Bee, H., Broverman, I. K., & Broverman, D.M. (1968). Sex-role stereotypes and self-concepts in college students. Journal of Consulting and Clinical Psychology, 32, 287-295.

Ruch, L. O. (1984). Dimensionality of the BSRI: A multi-dimensional analysis. Sex Roles, 10, 99-117.

Schacter, J., & Butts, H. (1968). Transference and countertransference in interracial analysis. American Psychoanalytic Journal, 16, 792-808.

Scott, W. A. (1965). Psychological and social correlates of international images. In H. C. Kelman (Ed.), International behavior: A social psychological analysis. New York: Holt, Rinehart & Winston.

Shapiro, R. (1975). Discrimination and community mental health. Civil Rights Digest, 8,

Sherman, J. (1980). Therapist attitudes and sex-role stereotyping. In A. Brodsky & R. Hare-Mustin (Eds.), Women and psychotherapy, An assessment of research and practice (pp. 35-63). New York: Guilford Press.

Smith, M. (1980). Sex bias in counseling and psychotherapy. Psychological Bulletin, 87, 392-407.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). The benefits of psychotherapy. Baltimore, MD: Johns Hopkins University Press.

Snider, J. F. (1979). The experience of successful psychotherapy as reported by "cured" schizophrenic patients and their therapists. Dissertation Abstracts International, 39, 3539B-3540B.

Spence, J. T., & Sawin, L. L. (1985). Images of masculinity and femininity: A reconceptualization. In V. E. O'Leary, R. K. Unger, & B. S. Wallston (Eds.), Women, gender and social psychology (pp. 35-66). Hillsdale, NJ: Erlbaum.

Stein, D. M., & Lambert, M. J. (1984). On the relationship between therapist experience and psychotherapy outcome. Clinical Psychology Review, 4, 127-142.

Sue, S. (1988). Psychotherapeutic service for ethnic minorities: Two decades of research findings. Meeting of the American Psychological Association (1987, New York, NY). American Psychologist, 43, 301-308.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. American Psychologist, 42, 37-45.

Taft, R. G., Jr. (1959). Ethnic stereotypes, attitudes, and familiarity: Australia. Journal of Social Psychology, 49, 177-186.

Tanney, M. F., & Birk, J. M. (1976). Women counselors for women clients? A review of the research. Counseling Psychologist, 6, 28-32.

Taylor, S. E. (1981). A categorization approach to stereotyping. In D.L. Hamilton (Ed.), Cognitive Processes in Stereotyping and Intergroup Behavior. Hillsdale, NJ: Lawrence Erlbaum.

Taylor, S. E., Fiske, S. T., Etcoff, N. L., and Ruderman, A. J. (1978). Categorical and contextual bases of person memory and stereotyping. Journal of Personality and Social Psychology, 36, 778-793.

Terestman, N., Miller, J. D., & Weber, J. J. (1974). Blue collar patients at a psychoanalytic clinic. American Journal of Psychiatry, 131, 261-266.

Terrell, F., & Terrell, S. (1984). Race of counselor, client sex, cultural mistrust level and premature termination from counseling among black clients. Journal of Counseling Psychology, 31, 371-375.

Triandis, H. C., & Vassiliou, V. (1967). Frequency of contact and stereotyping. Journal of Personality and Social Psychology, 7, 316-328.

Turner, B., & Turner, C. (1987 August). Age, sex, race and clinical judgments of mental health. Paper presented at the 95th Annual Convention of the American Psychological Association, New York, NY.

Turner, S., & Armstrong, S. (1981). Cross-racial psychotherapy: What the therapists say. Psychotherapy: Theory, Research and Practice, 18, 375-378.

Watkins, J. (1984). Comparison of cognitive therapy, pharmacotherapy and combination treatments. Unpublished manuscript.

Watson, C. R. (1981, November 30). Blacks don't need "black leaders." Newsweek, p. 25.

Whitley, B. E. (1979). Sex roles and psychotherapy: A current appraisal. Psychological Bulletin, 86, 1309-1321.

Wilder, D. A. (1978). Perceiving persons as a group: Effects on attributions of causality and beliefs. Social Psychology, 41, 12-23.

Williams, J. H. (Eds.). (1985). Psychology of Women (2nd ed.). New York, NY: W. W. Norton & Co., Inc.

Worchel, S., & Austin, W.G. (Eds.). (1986). Psychology of intergroup relations (2nd ed.). Chicago, Ill: Nelson-Hall, Inc.

Yamamoto, J., James, Q. C., Bloombaum, M., & Hattern, J. (1967). Racial factors in patient selection. American Journal of Psychiatry, 124, 630-636.

Zepplin, H., Sills, R. A., & Heath, M. W. (1987). Is age becoming irrelevant? An exploratory study of perceived age norms. International Journal of Aging and Human Development, 24, 241-256.